VETERANS' ADMINISTRATION MEDICAL CONSTRUCTION BUDGET FOR FISCAL YEAR 1986

HEARING

BEFORE

SUBCOMMITTEE ON
HOSPITALS AND HEALTH CARE

OF THE

COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

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VETERANS' ADMINISTRATION MEDICAL CONSTRUCTION BUDGET FOR FISCAL YEAR 1986

TUESDAY, MARCH 5, 1985

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The subcommittee met, pursuant to notice, at 9:13 a.m., in room 334, Cannon House Office Building, Hon. Bob Edgar presiding.

Present: Representatives Edgar, Mica, Evans, Kaptur, Mollohan, Penny, Staggers, Rowland of Georgia, Bryant, Kanjorski, Hammerschmidt, Smith, Bilirakis, Johnson, Molinari, Ridge, Hendon, and Rowland of Connecticut.

OPENING STATEMENT OF CHAIRMAN EDGAR

Mr. EDGAR. The Subcommittee on Hospitals and Health Care will come to order. I want to apologize to my colleagues for being late. Unfortunately, we sometimes have conflicting schedules, and this morning I had a breakfast that I couldn't get out of which is why I was late.

I will indicate to my colleagues that I will question the witnesses last, as it is the custom and rule that Members at the hearing get to ask questions in relationship to their arrival.

The subcommittee is meeting to receive testimony on the proposed fiscal year 1986 Veterans' Administration medical construction budget. The fiscal 1986 budget proposes drastic reductions in construction funds, which will delay construction of major replacement/modernization, hospital projects. Included in these delays are hospitals at Augusta, GA; New York City; Houston, TX; and Philadelphia, PA.

These deferrals will not only delay the needed upgrade of health care delivered to veterans in these geographic areas, but also result in increased cost to taxpayers due to the inflationary impact caused by delaying construction. We look forward to learning how these deferrals can be justified in view of the increased cost.

The very austere budget is over one-half of a billion dollars less than the VA 5-year medical construction needs assessment stated was required for fiscal year 1986. This past January, the chairman of the full committee, Sonny Montgomery, wrote to the Administrator concerning several issues regarding VA procedures for developing leasing prospectuses for outpatient clinics.

The chairman of the full committee was concerned that the 5-year plan for construction does not adequately address alternatives

being considered by the VA. He also addressed concerns with the planning process which is used in developing proposed leases, as it does not appear that it always agrees with VA's medical facilities needs report.

Also, it appears that the cost analysis figures used with the lease prospectuses are not clear and should be changed to include a statement of advantages and disadvantages of the proposed term of the lease, and why leasing is preferable to the VA's building its own facilities. It has been suggested that the VA consider consolidation of all agency-wide construction needs assessment into one volume, similar to that of the Department of Medicine and Surgery, which would include not only the Department of Medicine and Surgery but the Department of Veterans' Benefits and the Department of Memorial Affairs as well.

We look forward to the VA's responses to these concerns and suggestions.

Immediately following this hearing, the subcommittee will meet to discuss our recommendations to the full committee on the fiscal year 1986 medical care budget.

I would now like to recognize the ranking minority member of the subcommittee, the Honorable John Paul Hammerschmidt, for his remarks that he would like to make at this time.

STATEMENT OF HON. JOHN PAUL HAMMERSCHMIDT, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ARKANSAS

Mr. HAMMERSCHMIDT. Thank you, Mr. Chairman.

We meet today to consider a most important part of the Veterans' Administration budget request for fiscal year 1986. In these times of necessary fiscal restraint, the request is less than asked for originally by the VA, and yet it is a significant dollar amount that we are asked to support.

Mr. Chairman, the 1986 new budget authority is for $611.6 million, with the actual program level being $771.6 million because of a programming of $160 million from prior appropriations. This figure is relatively close to the program level for fiscal year 1985.

Of particular note is the fact that as we compare the budget requests, the latest 5-year needs assessment of the Veterans' Administration, we find that some 22 major projects in the assessment are not included. We recognize, of course, that the needs assessment is not a budget document even though there is an obvious relationship. The needed projects cover clinical improvements, an educational building, nursing homes, outpatient clinic improvements, and major renovations, modernizations, or replacement.

We can probably assume that most of these deletions are due to budgetary facts of life. But it would be helpful if our VA witnesses could enlighten us in this area. My concern is general in nature, but I note the deletion of several nursing home projects that once apparently had very high priority. The reasoning behind these deletions as compared to other projects in the 5-year needs assessment takes on some significance in view of the VA report on the aging veteran which was released just last fall, and which had a number of references to the future needs for additional nursing beds.

Mr. Chairman, many VA physical plants around the country need construction assistance. But we all recognize that only so much can be done in any 1 fiscal year. With comparatively minor adjustments, it is my feeling that this is a construction budget that takes into account the deficit problems of the Nation while also taking note of priorities that should and must be met if quality VA medical care is to be preserved. I would hope that our VA witnesses this morning will give testimony that will bolster that tentative conclusion.

Mr. Chairman, I notice that we have some very distinguished witnesses to open this panel discussion, and I am anxious to hear them. Thank you very much.

Mr. EDGAR. Thank you very much.

OPENING STATEMENT OF HON. MICHAEL BILIRAKIS

Mr. BILIRAKIS. Thank you, Mr. Chairman. I want to join you in welcoming all our distinguished witnesses here this morning as we consider the VA medical construction budget for fiscal year 1986. In particular, I want to welcome my friend and colleague in the Florida delegation, the Honorable Bill Nelson of the 11th District. I have no doubt that Bill will give us a fine presentation of the need for additional VA construction dollars in Florida and I know his constituents appreciate his strong advocacy for a VA hospital in central Florida.

While Florida has fared well in medical construction funding over the past few years in comparison to tother States, we are still seriously underfunded in relation to the size and growth of the State's veteran population. Quite simply, Florida faces a crisis of much greater magnitude than that faced by most other States, and the VA as a whole, when it comes to caring for the burgeoning population of elderly veterans in need of medical care.

To meet this tremendous need, two things are needed as far as construction funding is concerned. First, it is essential that we get the best possible use out of the resources that have already been invested in the State. But optimum efficiency of present resources will not be enough. It will also be necessary for us to commit an increased and steady level of construction dollars to Florida over the next few years so that the facilities will be there when the tidal wave of older veterans hits our shores.

Mr. EDGAR. Before hearing from our first witness, I would like to include in the hearing record statements submitted by the American Legion [1] and Amvets.[2]

Without objection, we will include these statements in the record:

Without objection, it is so ordered.

Mr. EDGAR. Our first witness this morning is the Honorable Jake Pickle from the great State of Texas. We appreciate your patience this morning, and we look forward to hearing your testimony.

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[1] See p. 57.
[2] See p. 68.

STATEMENT OF HON. J.J. PICKLE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. PICKLE. Well, thank you, Mr. Chairman.

I am very pleased and honored to be here to speak to you and to the members of this very distinguished committee.

May I ask permission to revise and extend my remarks.

Mr. EDGAR. Without objection, so ordered.

Mr. PICKLE. I think I might save time by going through a very brief statement, and then summarizing.

I am appearing here today because I have some 63,00 to 65,000 veterans in my district, and I have a deep concern for these veterans and the availability of outpatient clinic services. My veterans travel currently over 100 miles round trip to San Antonio, TX, or 200 miles, to Temple or Waco when they go to look for help at a medical clinic.

Now these, many of them, are aged veterans, and the infirm veterans have a difficult time traveling 200 miles round trip. I was notified last September that the VA had approved an outpatient clinic for Austin, and that the VA would begin studying workload estimates and space requirements. I maintained close contact with the VA Office of Facility Planning and I urged that this clinic be established.

The VA projects an estimated 33,000 visits per year at the clinic if it is established in Austin. Demand for the VA outpatient medical services has been proven by the VA study, and that estimate of demand is a minimum figure now because our area has grown enormously in the last 2 or 3 years and is going to continue to grow.

It is because of the expressed and proven demand of these services that I am convinced we ought to have an outpatient clinic, and I am concerned why the VA did not include it in their 1986 budget request. Now, I am mindful of what you said, Mr. Chairman, and what Mr. Hammerschmidt said, that you have budget restraints, and I can appreciate that, and we all are faced with that problem.

I also feel a very deep obligation to my veterans. When I think in terms of the fact that some 33,000 of these veterans need these services, and it was recommended, it seems to me like it ought to be included in this year budget.

So let me summarize by simply saying I have a large constituency, I have an airbase in my district. The VA study itself says there will be some 33,000 annual visits to a clinic. The VA study also says that about 10 counties around Austin would be covered, and I, in turn, have talked to and have written to Mr. Walters asking him to include this in this year's budget.

Now I am mindful that normally this committee will not include budget figures if it was not included in the VA's budget. But that is just a normal procedure, and I hope you do the abnormal by listening to this plea and providing funds for an Austin clinic. At least, Mr. Chairman, at the very least, the VA should allocate existing inhouse resources to the Austin project so that the review process can continue.

One or the other, and I hope you can help us find funds for the VA outpatient clinic.

That constitutes my statement, Mr. Chairman.

[Statement of Mr. Pickle appears on p. 69.]

Mr. EDGAR. Thank you very much.

Mr. Hammerschmidt.

Mr. HAMMERSCHMIDT. I do not have any questions, but I just want to observe that I do not know of anybody in the Congress, maybe in the country, that has more knowledge about the needs of aging people, it certainly is coming true in the veterans' needs as well, because of Mr. Pickle's service for so many years on the Social Security Subcommittee on Ways and Means. And now he has the Oversight Subcommittee, and I know how knowledgeable he is.

I know that the case he makes is very valid, and we want to do the very best we can with it, Jake.

Mr. PICKLE. I appreciate that.

Mr. EDGAR. Are there other questions from my colleagues on either side?

I have a question in terms of estimate cost. Have you seen any estimates of how much a new——

Mr. PICKLE. I have not. We have asked the VA for some of those estimates in my letter I wrote him last month. I know this may involve the leasing of facilities, but I do not have an accurate figure about the cost.

Mr. EDGAR. Is there a community hospital in the neighborhood approximately where you would like to see the location of the outpatient clinic?

Mr. PICKLE. No; the only community hospital we have would be at the airbase, Bergstrom Air Force Base. And it is overloaded now, when they cannot take care of their own.

Mr. EDGAR. But the airbase, let me ask you about the airbase hospital. Is it an acute care facility at the airbase that provides medical care for the service personnel?

Mr. PICKLE. Well, I am not certain. I am not certain. I have a constant appeal for veterans who say they cannot get in, they cannot be serviced, and they tell them they have to go to Waco or they have to go to San Antonio.

Mr. EDGAR. The reason I am asking is that we are trying to see if we can put some outpatient clinics next to existing facilities so that equipment can be shared and resources can be shared. If you are going to invest $8 or $10 or $12 million in an outpatient clinic and you make it freestanding, then you have to put in that clinic all of the kinds of clinical equipment; whereas if you place it next to that military facility to service the outpatient needs of those veterans, there may be a way in which you could share some of the resources and services both ways. That way, the VA might be able to help alleviate some of the overload at the medical facility in the military, and vice versa.

Mr. PICKLE. I would think that should offer a good possibility. And I will certainly look into that, too.

Mr. EDGAR. Well, I appreciate your testimony this morning, and we will ask of the VA witnesses the question of why this particular facility was not included.

Mr. PICKLE. Thank you, Mr. Chairman.

Ms. KAPTUR. Mr. Chairman.

Mr. EDGAR. Ms. Kaptur.

Ms. KAPTUR. Might I just ask one question of our colleague here?

Mr. Pickle, I wanted to ask you if, in the planning that was done, I heard the chairman say $7 to $8 million was to be spent on the clinic, so it would be——

Mr. EDGAR. No, no; let me just correct what the chairman was trying to say.

I asked Mr. Pickle whether or not there were any estimates of cost, and he did not know of any. The difference, I think, the facility that the VA is talking about in his area would be a leased facility, not a constructed facility. I was quoting construction costs anywhere from $8 to $12 million for an outpatient clinic, as a guess.

Ms. KAPTUR. Thank you, Mr. Chairman.

Mr. PICKLE. I will get those figures to you.

Mr. EDGAR. Thank you.

Mr. PICKLE. Thank you, Mr. Chairman.

Mr. EDGAR. Our next witness will be the Honorable Bill Nelson, and he comes from the great State of Florida, where we know how many veterans move into Florida every month.

Let me yield to my colleague.

STATEMENT OF HON. BILL NELSON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Mr. NELSON. Mr. Chairman, thank you.

I have a formal statement, and if I might, I would just like to share with you personally here, and if we can enter that formal statement in the record.

Mr. EDGAR. Without objection, your full statement will be made a part of the record.

Mr. NELSON. Mr. Chairman, I have the distinction, according to the 1980 census, of having more veterans in my congressional district than any other congressional district in the country. That is a distinction of honor, for, as you all know better than any, it is a pleasure to have those folks, to represent them.

Having that distinction, however, I might point out that there is not a VA hospital anywhere close to my congressional district. Now, a series of events have occurred over the course of the 6-plus years that I have been here that is moving us closer and closer to that reality. The first was when I came in here as a freshman, I asked the then Administrator, Max Cleland, to please come down and see the situation.

And he said that our outpatient clinic in Orlando was the most overcrowded that he had seen. And shortly thereafter we had a construction program to double it. But we knew at the time that as soon as it was completed that it would be completely overcrowded again. That was step No. 1.

Mr. Chairman Edgar, step No. 2 was the fact that you were gracious enough to bring this committee to central Florida in September 1983 for a hearing at my request in which you explored this subject of us needing a VA hospital. Then some things started popping.

Step No. 3 was that the Administrator released a 30-year study on the needs of veterans in Florida, and we found out that they

started moving toward breaking away from that long-standing policy that said that you had to have a VA hospital colocated with a medical school. Because what they found in Florida, as you know, we have so many veterans as you said, and they are located in places where the medical schools are not located.

Then the fourth step came when the VA released a report called the "Final Report on Future Bed Needs and Potential Sites for New VA Hospitals in Florida," which my colleague and a member of your committee, Mr. Mica, helped release. And lo and behold, they identified four areas where new hospitals ought to be built in Florida to meet needs between now and 1995. And hallelujah, one of those areas was east central Florida.

The fifth step occurred just a few months ago, and that was that Administrator Walters signed off and endorsed a report to move ahead with proceeding for such planning for such a hospital.

Now, the next step would be if in June, when they come out with their final 5-year construction schedule for the next 5 years, if they include this 470-bed facility for east central Florida within that 5-year construction schedule.

Mr. Chairman, you have an enormous influence. This committee has enormous influence in an informal way with the Veterans' Administration. And as the Congressman who represents the congressional district that has resident more veterans than any other congressional district in the country. I would ask you to continue to influence the process so that finally in east central Florida, that hospital will become a reality.

Thank you, Mr. Chairman.

[Statement of Hon. Bill Nelson appears on p. 70.]

Mr. EDGAR. Thank you very much.

I yield to my colleague, John Paul Hammerschmidt.

Mr. HAMMERSCHMIDT. Bill, thank you very much for your testimony. I recall that very valuable visit that we made down there, valuable to us because we gained a lot of information.

We appreciate your testimony here this morning. I do not have any questions.

Mr. EDGAR. Are there any other questions?

Mr. Mica.

Mr. MICA. Mr. Chairman, I would like to welcome our colleague. We came here together some 6 years ago, and we recognize the problems of veterans, as I have mentioned before the committee.

Bill, watch this.

How many veterans are there that move to Florida every month?

The COMMITTEE. 5,000.

Mr. MICA. See there?

Mr. NELSON. You have got them trained well, Mr. Mica.

Mr. MICA. 5,000 a month move to Florida. And we have a critical need there, though, and that is really what started all this. That 30-year study said Florida was the worst in the Nation.

And when they did that study, most of us in Florida were holding our breath because we thought the study would say, that it would justify one new hospital for the State of Florida, and we wondered, with 19 Members, where it was going to end up and in whose district and in what area of the State.

The study did not say, and incidentally, Members of the Congress had no input, it was done by the VA, it did not say we needed one. It said Florida was in such a critical condition that we needed three new hospitals and, I believe it was, three or four outpatient clinics, as well as renovation and modernization of almost every facility in the State.

I think that is what focused the attention on our State and our needs. That 30-year study told how really critical it was. I spent years with e staff working on this and I had no idea the figures were that high and the needs that great, though. I have mentioned it before that outpatient clinic in Miami, designed to see 135 people a day, and on that basis, I have been in Congress 6 years where they have seen less than 1,000 a day.

So, in doctor-patient ratio, evaluation, everything in our State really is in a difficult situation. And we recognize it is difficult in Pennsylvania, in California, in Virginia, West Virginia, throughout the United States. But we have a critical situation through these findings, and I think this study goes a long way to document that. My colleague, Mr. Nelson, others, Bilirakis, in fact, the entire Florida delegation, as I recall, endorsed this study and supported it, and went so far as to say we almost do not care where you build it, but let us get moving on it because the need in Florida is so critical.

So I appreciate your being here and to add to our voice of concern. We need to support the facilities in Florida, and I can assure you that this Member will continue above and beyond trying to let everybody know the number, to see if we cannot get some action on these facilities.

Mr. NELSON. And, Mr. Mica, I might point out that credit needs to be due to Administrator Walters is that he has kept politics out of this. They have done a very professional study by their staff in Florida as to what the bed needs are between now and 1995. And he is trying to proceed in that professional manner, and I appreciate that and I want that said for the record by me.

Mr. EDGAR. Mr. Hammerschmidt has a question, then I have one final question.

Mr. HAMMERSCHMIDT. Well, I just wanted, for the record, Bill, to ask you, has the VA given the central Florida site for a new hospital the highest priority nationwide? Do you know whether it——

Mr. NELSON. Well, we will know if in fact in the 5-year construction schedule if they include it in there. At this point, I cannot answer your question yes, because we do not know that they have. I stated a series of circumstances which are leading to that, but thus far, the VA has not established that priority.

Mr. HAMMERSCHMIDT. I noticed it was not in the 1986 budget, and I guess they just do not have all their preliminary work done on it, is why it has not settled down into a priority status.

Mr. NELSON. That is correct. And then, of course, you know, people get all uptight about the question of siting. Where would it be? First, you have to get it in the construction schedule, and then the VA professional staff would go out and determine where they want it located. The region that they are looking at is a nine-county region in east central Florida.

Mr. HAMMERSCHMIDT. But we do recognize, as you have stated, there is a great need there for one, possibly two.

Thank you, Bill.

Mr. NELSON. Thank you.

Mr. EDGAR. We appreciated your leadership when we had our hearing in Florida and the help with the information that you shared with us at that time.

Let me just ask you a couple very brief questions.

In terms of the process, do you have a medical center that is a teaching hospital anywhere in that nine-county region?

Mr. NELSON. No, sir.

Mr. EDGAR. What is the closest medical center that a hospital in your region could affiliate with?

Mr. NELSON. Well, the closest one is in Tampa at the University of South Florida, which is colocated with a veterans' hospital. And that is approximately, from the eastern portion of my district, say, the Cape Canaveral Kennedy Space Center area, that is approximately 160 to 170 miles.

Mr. EDGAR. Are there any other military hospitals in your nine-county area?

Mr. NELSON. Indeed. There is a military hospital, a small one, at Patrick Air Force Base which is near Melbourne. There is a much larger hospital facility at the Naval Training Equipment Center in Orlando.

Mr. EDGAR. Do you know if those military hospitals are at full utilization?

Mr. NELSON. Yes, they are, and if I might anticipate your next question, which definitely should be asked, what about the colocation of a VA hospital facility with such a military facility? And the fact is, at the Naval Training Center in Orlando, there is no room for expansion there with a major VA facility where it would be colocated on the Naval Training Center in Orlando.

With regard to the Patrick Air Force Base Hospital, there is room there to colocate a VA hospital, but since that is on the barrier island, and since from time to time, there is the threat of hurricane and there has had to be evacuation under the threat of hurricane of even the military hospital, the commanding officer of the Eastern Space and Missile Center has told me that he would recommend against such colocation because of those factors.

Mr. EDGAR. Is Cape Canaveral in your district?

Mr. NELSON. Yes, sir.

Mr. EDGAR. You know, with their plans to shoot people up into outer space as a burial benefit, maybe we would have to designate that a veterans' cemetery.

Mr. NELSON. Mr. Chairman, I have never thought about that.

Mr. EDGAR. I am just teasing.

I want you to remember that when Dan Mica has us in unison, say "5,000," the only reason we do that is we recognize that about 1,000 of them are from Pennsylvania, and we have to keep reminding him that while we send a lot of our veterans to Florida and they need care with new hospitals, we also keep a lot of our veterans in Philadelphia and Pittsburgh and some of the communities in the Northeast and Midwest. So we have to renovate those hospitals as well. So it is a balance between new construction and ren-

ovating existing facilities, and I just thought you should share that for the record.

Mr. HAMMERSCHMIDT. Would the chairman yield?

Mr. EDGAR. I yield to the gentleman.

Mr. HAMMERSCHMIDT. You were inquiring about the possibility of new hospital affiliation. I remember we went to Bay Pines, and, of course, that is a new hospital or a renovated hospital, and it is not affiliated, if I remember right.

Mr. NELSON. That is correct.

Mr. HAMMERSCHMIDT. I think they intend to affiliate with south Florida, but that may be in the distant future.

So your needs are such that and located in areas where it might not necessarily be a requirement to have an affiliation right off.

Mr. NELSON. The history on that, Mr. Hammerschmidt, is, that hospital was established way back years ago before the new policy arose. Another facility, a hospital facility in Lake City, was similarly located before the colocation policy came into vogue.

Since then, however, you find that the three VA hospitals in Florida are in Gainesville, Tampa, and Miami, which is exactly the colocation with the medical schools in Florida.

Mr. HAMMERSCHMIDT. Thank you.

Mr. EDGAR. Thank you very much. Appreciate your testimony. Are there any other questions?

Thank you.

Let me call on our next witness, the Honorable Jim Oberstar.

Jim, we appreciate your coming this morning. The full text of your statement will be made a part of the record, without objection. We ask that you either read or summarize. We have some other witnesses which will follow you, so we ask you to be brief.

STATEMENT OF HON. JAMES L. OBERSTAR, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MINNESOTA

Mr. OBERSTAR. Thank you very much, Mr. Chairman.

I do appreciate the pressures of the committees time, and I am very grateful for this opportunity to come before this committee with a very brief and very simple and direct message on behalf of the veterans, not only of northeastern Minnesota, but all of the northern tier of our State of Minnesota.

They have to travel great distances for medical care. If you can imagine an area the size of the east coast from Silver Spring to Hartford, CT, that is the size of my congressional district from north to south. It is about two-thirds the size of the entire State of Pennsylvania. It is about the size of all of New England combined. We have 60,000 veterans in that northern part of the State. They have to travel, right now, when they need assistance from the VA services, the equivalent of from here to New York City.

I think that is unreasonable, it is unfair, and in the economic times that we are experiencing in our part of the State with as much as 15 percent unemployment, with some communities that have as much as 80 percent unemployment, veterans' health insurance benefits have run out. We have some 8,000 to 10,000 miners in the iron ore mining industry who are out of work. That is more than 50 percent of the work force. Most of them have been out of

work for so long they have exhausted regular unemployment compensation, Federal supplemental compensation, trade adjustment assistance benefits, health insurance, and the only benefit they have left is the VA health insurance.

And if they have to travel all the way to the Twin Cities, stay at a motel or some other place where they have to pay for staying overnight, eat their meals out, and then travel all the way back, it adds another financial burden to these already hard-pressed people. Even when they are employed and they have to take a day off work and travel as far down as the Twin Cities, just consider, think of it in terms of your own district.

I see the gentlewoman from Connecticut. If the veterans in her district had to travel from there to Washington, DC, to get medical care, they would be up in arms. They would be marching on Hartford or on Washington, DC.

Well, that is the situation in northeastern Minnesota. We are asking a very modest amount of funding for the proposed outpatient clinic which has been recommended by the medical district for the State of Minnesota. It would be located in Duluth where there is a 2-year medical school, the University of Minnesota, Duluth branch, where there are three hospitals working with that medical school program. In fact, I have been proposing this idea of an out patient clinic for several years, going back to when we still had an air base. The air base is now closed: its infirmary, which could have been converted at a modest cost has now been taken over by a Federal prison, a minimum security prison facility.

But, meanwhile, unemployment has so devastated our area with the result that the hospitals have such open capacity that the VA could enter into a lease arrangement, for example, with St. Luke's Hospital in Duluth and for very little cost, far less than the million dollar figures I suggested in my prepared statement, could rent outpatient facilities right in the hospital and have access to all the hospital services, very, very minimal cost. A cooperative venture of this nature would keep a hospital open in Duluth which is desperately needed, in addition to providing outstanding medical service for all the veterans.

I urge the committee to include this proposal in the fiscal year 1986 budget.

[Statement of Mr. Oberstar appears on p. 70.]

Mr. EDGAR. Thank you very much for your testimony. I want you to know that I have been an advocate for looking at ways of sharing relationships between community hospitals and VA facilities, which makes a great deal of sense to me.

I am troubled sometimes that people misinterpret and think that I am talking about mainstreaming veterans' programs and putting it all back at the community level. I am not saying that at all. I think, in times of fiscal restraint and tight budgets, we may not be able to proliferate additional hospitals even if there is a need, but we may be able to have some outpatient clinics established which can address the outpatient needs of veterans and allow acute care to be provided in existing facilities and to put those VA outpatient clinics next to or near existing hospitals so that equipment can be shared both ways.

So you strike a responsive chord when you give your testimony, at least with this Member.

Mr. Hammerschmidt.

Mr. HAMMERSCHMIDT. Jim, thank you very much for your good testimony. I know that an outpatient clinic for the Duluth-Superior area would be the best solution, but until that is accomplished, I am sure you are familar with the provision that allows service-connected veterans, when they are over 40 miles from a VA hospital, get fee-basis service, or, of course, they can get transportation paid to the VA hospital. And while that may not be the best solution, at least it is a service that the VA does provide them I am sure that you would want to make any of your veterans who are not aware of that. But probably they all are.

Mr. OBERSTAR. The gentleman is correct, and if the gentleman had to process as many requests from veterans for—as we have had to—for vouchers, the gentleman would understand doubly why we think it is a good idea to have a clinic right nearby.

Mr. HAMMERSCHMIDT. Well, I would agree. But I wanted to call your attention. The other is an interim solution that——

Mr. OBERSTAR. The gentleman is correct.

Mr. HAMMERSCHMIDT [continuing]. Would speak to their needs.

Mr. OBERSTAR. And I appreciate his sensitivity, too.

Mr. HAMMERSCHMIDT. Thank you very much, Jim, for your statement.

Mr. EDGAR. Mr. Evans.

Mr. EVANS. Jim, I guess after listening to your testimony, I will never complain about my 14-county district again. It is a lot larger than my district.

I am not going to ask you a question directly on point, in regards to your testimony, but I have the same phenomenon with a lot of United Auto Workers losing health care benefits because they have been laid off more than 6 months. The VA is their only alternative. We have heard testimony from the VA that they would like to impose a means test on veterans, and I would think the means test problem would affect, probably, your formerly employed veterans as well as the veterans that happen to be United Auto Workers in my district because a lot of these folks have substantial assets. They might be unemployed for maybe 6 months, lose their health care benefits, but within that period have earned income, even within 6 months of the year, that might make them ineligible for a means tested program.

Would you have that same kind of problem in your district, where formerly employed people have a lot of assets and maybe some income within a calendar year if we impose a means test?

Mr. OBERSTAR. Well, first of all, in our area we do have a very serious problem. Take the community of Babbitt, which is up the north shore 40 miles inland from Lake Superior. The road ends at Babbitt. From there is the wilderness. You paddle from there on to Canada by canoe; 80 percent unemployment, homes that were valued $40,000 to $50,000 are now being bought for $5,000.

Now if you talk to a veteran who committed himself in World War II, spent time in Korea, is now out of work, can't get retraining, no relocation assistance, nowhere to go but right there in Babbitt and needs help, can't pay for it, and you say, sorry, fellow,

your house is still worth something and so we are going to means test you.

He is going to probably say something that we could not print in this record. And he is probably going to feel that he was means tested once before, when his country needed him, and he was brought into the service. And once is enough.

Mr. EVANS. We do not have any idea what those means tests are yet. I do not think we have seen the recommendations of what they are even proposing, so I cannot tell you if it would include the house, or a late model car, or whatever. But one of the biggest worries of Members whose districts have high unemployment is that so many people rely on the VA as a fallback system, but will not have it if that means test is imposed.

Mr. OBERSTAR. There may be situations where means testing is workable and practical, but I think that in a veterans health program it would be grossly unfair.

Mr. EVANS. All right. Thank you.

Thank you, Mr. Chairman.

Mr. EDGAR. Any other of my colleagues?

Ms. KAPTUR. Mr. Chairman, might I ask your judgment on something?

Congressman Oberstar mentioned that a second alternative is sharing facilities with existing hospitals in the area. Does the VA have much of a history in that?

Mr. EDGAR. No; there has been great resistance to that by, particularly, the service organizations because of the fear of mainstreaming. But I think that we are developing a new concept of these shared relationships and I think in the future we have got to do more of that because medical equipment is becoming more and more expensive. If you are going to do blood tests, there is no reason why one facility could just have access to that equipment, or CAT scanners, or whatever other sophisticated equipment you are using in a clinic or in a hospital. We ought to share with the community, I think, those common resources where possible.

Ms. KAPTUR. Have you ever seen a report from the VA that summarizes the extent of that activity to date?

Mr. EDGAR. No; we will have an opportunity to ask that question as soon as our next witness is completed, because the VA will be here.

Mr. HAMMERSCHMIDT. Mr. Chairman, let me just make a comment here, because some of our memories do not go back far enough in the VA program, perhaps.

I was listening to Jim's comments about the means test. From 1930 until this committee and the Congress changed the law about 1971 or 1972, there were not any outpatient visits allowed for nonservice-connected people. That is something we changed about 1971 or 1972. So as a result then your outpatient services went from about 1.5 million to 18 million. You know, we created this problem, you might say, maybe without thinking it totally through, and I did not know how many people were aware that we did not even have the problem in 1970, because we did not allow it.

So we just expanded those benefits greatly, and now we are having a hard time coping with it, physical plants, budgetwise, and otherwise.

Mr. EDGAR. It would be interesting, though, to also ask the other question and that is with the outpatient clinics: How many acute care visits have we been able to diminish? Have we been able to provide some preventive health care and some preventive health medicine by having outpatient clinics as opposed to only putting people in acute care facilities?

It is a real tough question, and I recognize John Paul's comment about expanding benefits and access to those benefits, particularly to non-service-connected veterans, in the early 1970's.

Mr. OBERSTAR. Mr. Chairman, with the DRG concept now in place in hospitals under our Medicare Program, by establishing an outpatient clinic system, you would be creating in the veteran health care system a program analogous to the DRG where a great deal of work now is being done on an outpatient basis in hospitals under those DRG's, and I think that this is going to reduce costs dramatically in line with what we are doing on the civilian health care side.

Mr. EDGAR. Thank you very much.

Having no other persons interested in asking questions, I call the Honorable William Thomas to present his statement.

Mr. EDGAR. Without objection, your statement will be received into the record and I would encourage you to be as brief as possible.

Mr. THOMAS. Mr. Chairman, I would ask unanimous consent that the statement to the Veterans Affairs Subcommittee on Hospital and Health Care approve the statement of Mr. Rolf A. Shepard, director of the Kern County Veterans Service Department as well and place it in the record.

Mr. EDGAR. Without objection, so ordered.

Mr. THOMAS. Thank you, Mr. Chairman.

[Statement of Mr. Shepard appears on p. 71.]

STATEMENT OF HON. WILLIAM THOMAS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. THOMAS. I won't go into a statistical analysis of my district. It's sufficient to say that mine is even larger than Mr. Oberstar's. In California, believe it or not, with 45 Congressmen, my district goes from the Pacific Ocean to the Nevada border. It's about 30,000 square miles and that's east and west.

We have VA facilities north and south—about 100 miles north and not quite 100 miles south—over a 4,000-foot pass, which is the pass through the mountains, snowed in during the winter and so on.

We have approval for a 1987 outpatient clinic.

I also will tell the chairman that we have had a number of visits from folks who want to know why, given the vouchers that they have and they are able to go over the hill down to Sepulveda for blood tests and then they find out that for some reason their appointment has been canceled and they have to come back. It's these routine kinds of maintenance services that I think the outpatient clinic is ideal for, and that to a certain extent I would hope that this committee doesn't think that they created a need, that in fact they were responsive to a problem in creating the outpatient

clinics and it is the cheapest way in which we can meet these real problems.

We have an area that has about a population of over 50,000 veterans and it's believed to be between 20,000 and 27,000 clinics visits per year. I won't go into all the statistics. They're in the testimony. But, I want you to appreciate that over 50 percent—close to 54 percent are of the visits from Kern County's disabled veterans are service connected. These are not non-service-connected visits.

When you examine all of the statistics in terms of the average age and the health care visits per veteran, which is less than half the national average, that the profile emerging from this statistic shows a populace with greater than average need for VA care but actually receive only half the national average of VA health care.

Everyone in the community is supportive. It's absolutely total support. We had in fact petitions of over 15,000 individuals signed—6,000 of them veteran. The board of supervisors, the grand jury, all of the medical society is in support of this and I would urge the subcommittee to consider allocating funds in the 1986 health care budget.

The outpatient clinic is clearly needed. There is a pressing need. We do not want to duplicate any facilities. We do not want to duplicate any structures. We simply want to provide, at the least possible cost, an outpatient clinic which will provide minimal services.

Any of the significant acute care will go down to Sepulveda or north to Fresno, but the numbers are overwhelming and the need is clearly there and it's long overdue, and I would request you examine the 1986 budget rather than the 1987 budget.

I would be open for any questions.

[The statement of Mr. Thomas appears on p. 72.]

Mr. EDGAR. Thank you for your strong statement.

Mr. Hammerschmidt.

Mr. HAMMERSCHMIDT. I have no questions.

I want to thank Bill for his good testimony and we'll certain take a careful look at it.

Thank you, sir.

Mr. THOMAS. I wanted to be brief, but I want you to make sure that I could have taken a lot more time and presented a lot more forceful case but I understand your pressing needs.

Mr. EDGAR. Are there any other members who want to ask questions?

Let me just ask you whether or not a site has been selected and whether or not either construction or lease has been the method that you would like to see processed?

Mr. THOMAS. We are totally flexible on that point, if you'll examine some material in terms of planning. It can be leased. There are facilities that can be leased, existing facilities. It would be a minimum construction cost involved in refurbishing them—about $270,000 is outlined in the overall plan—and we do not envision constructing. We envision slight remodeling of existing facilities located in such a way that we can avail ourselves of the present medical support services.

Mr. EDGAR. Do you have a State Veterans Home Program?

Mr. THOMAS. I do not know. My assumption is I do in California. I would assume that we do.

Mr. EDGAR. Do you know if the State has a surplus?

Mr. THOMAS. I do not know that.

Mr. EDGAR. Do you think the State would share if, let's say, we were going to construct a new facility and we would commit $5 million. Would the State commit $2 million?

Mr. THOMAS. New construction in Bakersfield? Is that what you're talking about? $5 million is far beyond any amount that we would ever be asking for. Let's talk a $1.5 million. That's where we are in terms of total costs.

Mr. EDGAR. Would the State come up with $500,000?

Mr. THOMAS. If you're going to come up with $1 million I certainly would do everything I could.

Mr. EDGAR. It's not been done before but it occurred to me as I heard the previous witnesses, that we do have a very successful State Home Program where we share the construction cost and the per diem cost with the State. Maybe in our creative new look at how we deliver services there might be a shared relationship, particularly given all these States that have surpluses and have been asking us to balance the budget and do other things. That maybe they want to share some of their resources.

Mr. THOMAS. I would say to the gentleman, although I'm not authorized by anyone to say this, that I would certainly commit myself that when we talk about shared we wouldn't even stop at the State level. That I think county and local facilities—if they really want it, I think a good way to determine is to see if they are willing to participate.

I know that's the condition in Kern County.

Mr. HAMMERSCHMIDT. Will the chairman yield?

Mr. EDGAR. I yield to the gentleman.

Mr. HAMMERSCHMIDT. I appreciate your trying to get into other people's surpluses, but, you know, the Veterans Program is a national program. It's a national commitment. It's not the responsibility of the State, the county, or the city to take care of it.

I just want to point that out.

Mr. EDGAR. I agree with the gentleman to that point, except that as part of our national commitment we have done, I think, a very good job of working with the States in a Federal-State partnership and we've expanded nursing homes, domiciliary care facilities that would not exist if it were not for that State-Federal relationship.

I see some reason to at least explore the possibility of some minimal amounts of cost sharing at the community level, at the State level, and at the Federal level, if in fact that's the only way we can respond rather than have no facility at all to provide these services. That's my only point and I'm not arguing it as a fait accompli. I'm simply suggesting that that is an option that we can explore.

Mr. HAMMERSCHMIDT. If the gentleman would yield further, I just want to make the point that when you do that you move into social welfare activities and that's fine. You know, that has merit. Except, why then, you leave the responsibility that the VA has to take care of those who served their country. That's my point.

I thank the gentleman for yielding.

Mr. EDGAR. Any of my other colleagues wish to raise an issue?

Thank you very much.

Mr. THOMAS. May I respond just very briefly, Mr. Chairman, and that is that I've indicated that a majority of the problems are service related in my area. We're talking about a growing population. Principally, World War II veterans are the ones who aren't able to avail themselves of the facilities more than 100 miles away. There is no question that it is the national responsibility.

However, if you'll ask these individuals in terms of their option as to what the plaque on the door should say in terms of who participated to put the facility there, the bottom line is that they want the facility there.

Mr. EDGAR. Thank you very much.

We'll now hear from the Deputy Chief Medical Director of the Veterans Administration, Dr. John Gronvall.

We welcome you this morning. We thank you for your patience. We know that you have an army of people with you and we hope that you'll begin by introducing your family.

We also want to let all of your staff and experts there know that the size of your name tag does not indicate our feeling about your responsibility.

STATEMENT OF JOHN A. GRONVALL, M.D., DEPUTY CHIEF MEDICAL DIRECTOR, VETERANS' ADMINISTRATION

Dr. GRONVALL. Thank you very much, Mr. Chairman. It is a pleasure to be here and I'm pleased to introduce my colleagues who are here at the table with me.

First, to my right, Susan Livingstone, who is the Associate Deputy Administrator for Logistics in whose area of responsibility the construction program falls.

Next to her, Gerald Neumann, who directs the Program Control Office in our Office of Construction.

And, to my far right, Mr. William Fote, who is the Deputy Director of the Office of Construction.

Sitting next to me, on my left, Richard Falco, who heads our Facility Engineering and Planning Office in the Department of Medicine and Surgery.

And, then, on my far left, Jim Gregg, who is the Deputy Director of our Planning Office, the MEDIPP Planning Office who handles the development of plans for the future of the Veterans' Administration.

Mr. Chairman, I have a formal statement which I'd like to submit for the record, if it's your pleasure.

Mr. EDGAR. Without objection, your formal statement will be made a part of the record at this point.

Dr. GRONVALL. Thank you very much. Then, let me, if I may, in a very brief way, summarize our appearance here today by saying that we're, of course, presenting the medical facility construction request for 1986. This request is built out of our commitment to maintain a very high quality comprehensive health care delivery system for the Nation's veterans.

As you are well aware, the total construction budget request this year is $722,893,000. Within that, $160 million will come from funds available from previous appropriations.

We are requesting in this budget approval of some 31 major projects. In addition, $19 million for the advance planning fund and $35 million for asbestos abatement and $20 million for the design fund.

In the major program the largest projects will be the initiation of a new replacement facility at Houston that will include 927 hospital beds and 120 nursing home beds. We're proposing to replace all of the acute medical and surgical patient care buildings at Mountain Home, TN, and to enter into phase two of the construction program at Philadelphia. That would include the 240 bed nursing home and a major modernization project.

Subsequently, as you are aware, at Philadelphia we would construct the clinical addition, make a renovation of beds, add a parking structure and correct a number of other deficiencies.

This budget also includes two new nursing homes at Amarillo and at Tucson and a number of other projects.

In the minor construction program our request of $194,400,000 would include some 250 projects, and I should note here that we've included some $10 million for conversion of hospital beds to nursing home beds.

Mr. Chairman, this construction budget comes out of our planning system, through which we look not only at current but future needs of our health care programs throughout the Nation, translate that with the help of plans at each individual medical center, accumulate those projects into our 5-year needs assessment and then refine out of that the specific budget request.

We'll be pleased, of course, to answer any questions that you have on the details of this construction request.

Thank you very much.

[The statement of Dr. Gronvall appears on p. 73.]

Mr. EDGAR. Thank you very much. Let me yield to my colleague, John Paul Hammerschmidt.

Mr. HAMMERSCHMIDT. Thank you, Dr. Gronvall.

If you had the decision capacity instead of others and if you had been given a budget figure to get down to, would the budget request before us be different and, if so, how would it differ?

Dr. GRONVALL. I want to be sure of the middle part of that question with reference to the budget.

Mr. HAMMERSCHMIDT. If you had the decisionmaking capacity instead of others——

Dr. GRONVALL. Yes.

Mr. HAMMERSCHMIDT [continuing]. And if you'd been given a budget figure to get down to, would the budget request before us be different and, if so, how would it differ?

Dr. GRONVALL. Yes; I think it would be different. It depends on what the definition is of having the decisionmaking authority. This budget, along with the operating budget request for the Veterans' Administration for 1986, is part of a freeze year in which, during the process of executive branch review of all of our budget proposals, a decision was made not to include in this construction budget as part of the deficit reduction program expansionary projects or commitments that would be viewed as expansionary.

So, in the process of preparing this construction budget there was a detailed reassessment of the projects that we had proposed

from the Veterans' Administration and that led to some significant revisions of the total list of projects that are now before you.

Mr. HAMMERSCHMIDT. Well, even operating within those constraints, would you have made different decisions if they had just been done in DM&S and you had seen what the needs were across the Nation or do you think you would have come up with the same list?

Dr. GRONVALL. I'm not sure that I can really answer that accurately. I am confident that this list of projects fundamentally reflects the priorities that are developed through our planning system and those priorities, of course, are submitted year-by-year in the 5-year needs assessment on the list of 10.

I can say that in the prioritization of the list of 10 projects that we have previously submitted, the order of the projects now included for major construction is not exactly the same as the prioritization that had been previously submitted. Those projects had been, in order, Houston, Mountain Home, Augusta, and Philadelphia.

When the budget was constrained and we got into the final process of balancing those priorities against the need to do the greatest number of projects and to initiate the most desirable construction program, the decision was made after reviewing both the Philadelphia project and the Augusta project that it would be possible within the total amount of funds available in 1986 to begin a major component of the total Philadelphia project. So that was included in the budget rather than Augusta, which would not have been possible in view of the total amount of funds available.

Mr. HAMMERSCHMIDT. If Congress gives you additional funds for the State Grant Program can you effectively use them to reduce your backlog?

Dr. GRONVALL. Yes; I should comment additionally that we're proposing legislation, as you know, that would delete one of the restrictions in that program related to the one-third funding obligation role and that also would assist in reducing the backlog.

Mr. HAMMERSCHMIDT. Please provide for the record, if you would, an update on your future plans for Baltimore, Allen Park, NY, and Augusta.

Dr. GRONVALL. I'd be pleased to do so.

Mr. HAMMERSCHMIDT. Please supply that for the record for us.

Dr. GRONVALL. I'd be pleased to.

[Subsequently, the Veterans' Administration furnished the following information:]

We have had a task force evaluating the Baltimore area veterans' health care construction needs for the 1990's. The report has been prepared and is currently under going executive review. When the review is completed, copies of the report will be sent to the Senate and House Apporopriations and Veterans Affairs Committees.

The Agency is proceeding with its efforts to finalize a consulant contract to revise the environmental impact statement [EIS] to address a split facility concept as a potential alternative for the replacement/modernization of VAMC Allen Park, MI. At this point, it is estimated that the Supplemental Draft EIS can be distributed for public review by mid-July 1985. If the schedule is maintained, a record of decision as to the selected alternative for the replacement/modernizatin could be signed by the Administrator in December 1985.

After executive review, the monies allocated in the replacement/modernization category were insufficient to fully fund the Philadelphia project, and could not fund any portion of New York or Augusta projects. If funding is available for the remain-

ing phases of the Philadelphia project in fiscal year 1987, there will b minimal disruption to the overall construction schedule. We anticipate that funding for the New York and Augusta projects will be submitted for consideration as part of the fiscal year 1987 budget.

Mr. HAMMERSCHMIDT. And, could you give us a breakdown of your total number of construction employees? How many are in central office? How many are in the field? How many are in the field other than construction, such as land management, liaison with GSA, preservation, et cetera?

Dr. GRONVALL. We would be pleased to.

Mr. HAMMERSCHMIDT. If you could just supply that for the record it would save us time.

Dr. GRONVALL. We surely would.

[Subsequently, the Veterans' Administration furnished the following information:]

The Office of Construction requests an FTEE of 710 for FY 1986 which is a reduction of 30 from the adjusted FY 1985 level. Of this, 468 FTEE are located in Central Office. The remaining 242 are for the Resident Engineer Staff which supervise construction projects located at various construction sites in the field. They perform no other function other than field supervision.

Mr. HAMMERSCHMIDT. Dr. Gronvall, what is the consequence of not having up to state-of-the-art equipment, such as magnetic resonance imaging units, at least in some of your hospitals and do you buy that service on the outside?

Dr. GRONVALL. Medical technology, of course, is rapidly evolving due to the research that's gone on in this country, much of it in the VA, and so I would say it is a continual struggle for us within the Veterans' Administration as well as all hospitals to accomplish new technology which is so desirable for treatment of patients.

We have plans in regard to magnetic resonance imaging. They involve a number of our centers. We're also working collaboratively with university hospitals through affiliation mechanisms to try as rapidly as we can to make that new technology available to veterans throughout the country.

We could provide specific details of where and when we believe we'll have magnetic resonance imaging in place in our individual centers, if you would like.

Mr. HAMMERSCHMIDT. Thank you very much, sir, for your responses. I see my time is up, and all the members of your team are pretty familiar to us, except the one on your right and that's Ms. Livingstone and we want to compliment her on her new position. We're looking forward to working with her.

Ms. LIVINGSTONE. Thank you.

Mr. EDGAR. Thank you. Dr. Gronvall, let me ask a question quickly and then I'll pass to my colleagues.

On the submission that you sent up, which is this large document that says constructions programs, volume III, fiscal year 1986, on page 1335, under the Houston facility, you list for the cost of new construction alterations, the subtotal of $173,349,000. Is that correct?

Ms. LIVINGSTONE. You're talking about the obligation plan?

Mr. EDGAR. I'm talking about project cost summary 0.7 of Construction Major Projects, Veterans' Administration Medical Center, Houston, TX.

Ms. LIVINGSTONE. That's correct. That's an uninflated number.

Mr. EDGAR. OK, $173,349,000. Is that correct?

Ms. LIVINGSTONE. The net construction, including new construction and alterations.

Mr. EDGAR. New construction alterations.

Yet your request is $190 million. Can you explain the difference?

Ms. LIVINGSTONE. Part of that difference would be incorporating the escalation of this, the outyear figures, when those awards are being made. We also have contingencies and impact funds included in the $190 million, which would account for the differences.

Mr. EDGAR. Well, that's included down at 5-percent construction contingency which is a 5-percent figure.

Ms. LIVINGSTONE. That's correct, but it's included in our request in the budget for the Houston project of $190 million which includes what we would require for the phases to be funded, not only for the base construction but also escalation to award and the impact funds and contingencies for those awards as well.

Mr. EDGAR. Why do you then on page 1385 indicate that in 1986 the amount of money that will be unobligated will be as large as the money that you're seeking to obligate?

Ms. LIVINGSTONE. The request for the Houston project——

Mr. EDGAR. Before you begin, it's $189,310,000 listed on page 1385. So, you're asking for $190 million. You're not going to obligate $189,310,000. It's a bit troubling to us and we're interested in why that is.

Ms. LIVINGSTONE [continuing]. Yes, sir. The Houston project request in the fical year 1986 budget provides for construction fundings for three phases of the Houston project. In fiscal year 1986 we are only going to be able to award one of those phases, which is the earthwork and foundations for the main hospital replacement at Houston.

It's been the policy, I believe agreed to by this committee and certainly within the VA as well, not to request from Congress partial funding for just the structural foundation for a building. We request full funding so that we can sufficiently fund it through completion, which we've done in this instance, although we cannot obligate, as you've noted, the major bulk of those moneys until the following fiscal year.

Mr. EDGAR. So, you're only—according to a February 14 letter that you sent up to the committee, you're only really obligating funds in fiscal year 1986 for the Houston project for phase I, earthwork, foundations, and framing up to the first floor.

Ms. LIVINGSTONE. That's correct. And, the theory here is that we do not request from you just funds for a hole in the ground. We need to ensure that we have sufficient funds to complete a fully functional and useable unit. So, that's what we did in the case of Houston.

Mr. EDGAR. But, then in a sense—and I'm not quarreling necessarily with that policy—you are putting a block of funds in that you know will not be obligated until 1987-88?

Ms. LIVINGSTONE. That's correct.

Mr. EDGAR. Those funds will be put where?

Ms. LIVINGSTONE. Remain unobligated.

Mr. EDGAR. Will they be protected to the VA?

Mr. NEUMANN. They will remain unobligated until the next phases proceed.

Mr. EDGAR. Will they be protected to the VA.

Mr. NEUMANN. Yes, sir.

Mr. EDGAR. And protected to that hospital.

Ms. LIVINGSTONE. Yes, sir. Reserved for that project.

Mr. EDGAR. Is there a legal bar for providing multiyear funding or split funding for projects so that the outlay of dollars more closely follows the actual need for those expenditures. Do you have any legal constraint in law that says that you could not obligate funds if we, let's say, reduced that money but made it high enough to complete that first phase. Is there any legal bar to us doing that?

Ms. LIVINGSTONE. I'm not sure if I know the answer to that. We do have a VA Assistant General Counsel here and perhaps he, William E. Thomas, Jr., could respond to that.

Mr. THOMAS. We could have contracts each containing a clause stating that the contract's provisions are subject to the availability of funds in case the additional moneys were not forthcoming.

Mr. EDGAR. Thank you. Let me yield to my colleague, Mr. Evans.

Mr. EVANS. Mr. Chairman, I'd yield back to you if you need further time.

Mr. EDGAR. I have additional time at the end.

Mr. EVANS. No questions.

Mr. EDGAR. Mr. Bilirakis.

Mr. BILIRAKIS. Thank you, Mr. Chairman.

Doctor, I'm not sure how to ask this, the advance planning fund process that you referred to in your formal testimony includes the MEDIPP planning and medical center facility plans and 5-year medical facility construction needs assessment, et cetera. Does that reflect the actual needs completely ignoring OMB, et cetera, et cetera, for our Nation's veterans?

Dr. GRONVALL. During the past several years, we've submitted each July 1 to the Congress the VA's 5-year facility needs assessment. That document was our best effort to document VA's needs and to project them forward for 5 years. It is meant to be a comprehensive statement of need in each of our facilities for the programs of care to veterans.

Mr. BILIRAKIS. Completely ignoring the need for dollars, et cetera, at that point. Is that right?

Dr. GRONVALL. I think it would be impossible to say completely ignoring the need for dollars, because as one establishes criteria for what kind of facilities are going to be planned and built and what kind of programs are going to be operated, that takes into account I would say the general status of the system, prioritization, the state-of-the-art in medical care. That evaluation, projected across the country, takes into account the availability of funds for medical programs. So, in that general way, all planning operates within some kind of constraint, but the 5-year facility needs assessment specifically does not start with a budget figure for one of the outyears and then build need only into that budget.

Mr. BILIRAKIS. Well, my concern is do we have an overall picture in terms of needs over a period of time and then do we have recommendations by the Veterans' Administration as to how to meet those needs?

The chairman referred to the cooperation of State and local authorities earlier; and of course, I also understand Mr. Hammerschmidt's concern. I have the same concern.

Veterans have earned by virtue of their service these benefits from the Veterans' Administration. I hate to call them even benefits. It is a matter of their rights.

But, what I'm wondering is should we not look at the overall picture of what the actual needs are and what financial needs are contemplated? Should we not be looking at and maybe setting aside some of our philosophies, if you will, and looking at the actual alternatives. There are alternative proposals as to how to reach those needs. I don't think that we're doing that veteran in Minnesota or Wisconsin a darn bit of good by saying, "Hey, we just don't have enough money. Money does not grow on trees, but we refuse to budget as far as any alternative proposals or looking at any alternative means are concerned."

That veteran is not going to understand that. He wants his needs to be met.

I'm not sure if it's a question or whether it's a statement, but basically I think it's just important when we look at overall plans that we also look at the alternative proposals so that we could actually sit down with the veterans groups and go over those with them.

Dr. GRONVALL. I very much appreciate your statement and agree with it. Let me make a very brief comment.

One of the things in the past several years that Mr. Walters has been particularly anxious to insure is that our planning system identifies needs and describes need so that we don't in a sense start with some assumption about availability of funds and then force our planning to fit that assumption.

So, we have attempted to build our program planning and our facility needs assessment on that basis. The converion of all those needs to an actual budget request takes many other factors into account, forces prioritization, and causes us increasingly to look for other alternative ways of doing things. There was discussion on this point earlier, but I think particularly in the past 2 or 3 years we have, with considerably increased vigor, pursued sharing agreements, with military hospitals and other sharing agreements with other kinds of hospitals. We do have some limitations on our authority to enter into such agreements with community hospitals, but we have had a rapidly growing number of other ways of accomplishing the same mission, such as turning to contract care, fee basis care, sharing agreements, et cetera.

I think we also have—and this is my final comment—the difficult problem of prioritizing the needs for acute inpatient care, extended care, nursing home care, and nursing home care done through the VA in collaboration with States—with the State Home Program. I can tell you that the sum total of our budget proposals and program proposals represents our best effort to make all of those prioritization decisions and then it does get constrained by plans as to what a total budget policy is going to be. But, we build that out of a very broad-based planning consideration.

Mr. EDGAR. Thank you. Before yielding to Dr. Rowland, who will be next, I'd like to ask a question of legal counsel, again referring back to my earlier question.

You had indicated that there would be no legal impediment to not having full construction. Let me ask you this. You answered by stating that you would need a statement in the contract of some nature. Is that correct?

If in fact we authorized $173,349,000 for the Houston project, which included the new construction, the alterations, but excluded the construction contingency and the technical services fund, would you still need those technical statements in the contract if in fact a full authorization was made for the construction and alterations?

Mr. THOMAS. Yes, sir.

Mr. EDGAR. Why is that?

Mr. THOMAS. Especially for the contingencies.

Well, you can have an Antideficiency Act violation, if, that is, we got to a situation where the $170 some million was spent and they encountered a differing site condition or some other unforeseen circumstance occurred where we would have to stop the contractor and not let him proceed because we don't have sufficient funds to cover the situation.

Mr. EDGAR. But, we've already authorized the total 200 and some-odd million dollars' worth of projects for Houston, so that there would already be authorization. You simply wouldn't be able to draw down on those funds until we replenish them in 1987 or 1988. Is that not correct?

Mr. THOMAS. That's correct; we'd have the authorization but we would not have the ability to spend it.

Ms. LIVINGSTONE. In the meantime it could result in delay claims, for instance, from the contractor.

Mr. EDGAR. I don't understand that for fiscal year 1986 and I don't understand it for the contract itself. We are contracting for fiscal year 1986 to complete phase I. We are authorizing the full hospital and alterations and it doesn't make any difference to the person we're giving the contract to whether or not we have all the funds available in 1986 or 1987. What makes their concern is whether or not they get fully paid and with the intention of Congress to fully fund this project, I guess I can't understand if you're going to have $189 million unobligated. You've made a commitment for full construction, full renovation. You only need a portion of that for 1986. Why you'd have to have a contractual bar or a contractual statement——

Mr. THOMS. Well, if phase I is a million dollars and we receive that million we would not need it in that particular phase I contract.

Mr. EDGAR [continuing]. That's correct. So, in the phase I contract, which is what is at stake in the 1986 budget, you would not need in phase I contract with whatever contractual group you're working with any constitutional bar because you'd have $189 million of unobligated funds to cover any overrun and if it cost that much to dig a hole in the group and put the foundation in we're all in big trouble.

You would need it in phase II and phase III perhaps, if the funds weren't fully there. Isn't that correct?

Mr. THOMAS. Yes; well, obviously contracts would be coming along. We don't wait until phase I finishes before we start the contracting process for phase II.

If we go out on the street with bids we must have the money.

Mr. EDGAR. Do you plan to go out in the street for bids for phase II in fiscal year 1986?

Mr. FOTE. We would not go—we would be in fiscal year 1987 before we go out on the street on phase II.

Mr. EDGAR. Thank you very much. Dr. Rowland.

Dr. ROWLAND. Thank you, Mr. Chairman.

Dr. Gronvall, would you give me a general overview of the status of renovation of existing medical care facilities for fiscal year 1986?

Dr. GRONVALL. I want to be sure I know what you mean by a general status overview.

Dr. ROWLAND. I want to know if there are going to be continuation of renovation of medical care facilities? If that's going to be reduced or just what's going to be taking place?

Dr. GRONVALL. The budget certainly includes funds for continuation of the overall renovation program. Mr. Falco I think could speak more specifically.

Mr. FALCO. Basically, this budget is about the same as all previous budgets that we've submitted in that the categories of work and replacement and modernization that we've been discussing—there are three projects in this budget. And, as has been discussed earlier, a few have been put back to be consistent with the administration's policy.

We've got a large number of fire and safety projects. We're doing a lot of general projects. We're doing a couple of seismic projects, and also electrical, and a couple of clinical improvements.

It's the expansion of the system that was part of the presidential budget initiative that this budget is different than previous budgets.

Dr. ROWLAND. So, there is some reduction insofar as percentage increase might be concerned. There is some reduction over preceding years?

Mr. FALCO. Not from preceding years because the budget is predicated on a freeze and it's pretty consistent between last year's program level and this year's program level.

Dr. ROWLAND. For renovation?

Mr. FALCO. For renovations. It is less than we had originally posed through our needs requirements.

Dr. ROWLAND. I believe my colleague, John Paul Hammerschmidt, has already asked for information on those projects that have been deleted for this upcoming fiscal year to be submitted for the record.

Mr. EDGAR. That's correct.

Dr. ROWLAND. There's one other thing that I'd like to ask about medicine in general as we are moving more toward outpatient treatment and more toward home health care.

Can you give me some idea about what the VA is planning for future years, moving in those directions?

Dr. GRONVALL. Absolutely. The Outpatient Treatment Program of the VA has been the fastest growing component of our medical care system and in recent years we've shifted significantly large numbers of patients from hospital care to outpatient care. We continue that planning and particularly in view of the increasing needs of older veterans, we have initiated a number of pilot programs in regard to hospital-based home care, other alternatives to having patients in the hospital and so that planning has been a centerpiece of our view of the future. So, we absolutely are going in that direction.

Dr. ROWLAND. You're moving toward more home health care?

Dr. GRONVALL. Yes.

Dr. ROWLAND. In the VA?

Dr. GRONVALL. Yes.

Dr. ROWLAND. Thank you.

Thank you, Mr. Chairman.

Mr. EDGAR. It should be stated for the record there are no funds available in the 1986 budget, or very few funds, to do the innovative, creative home health care initiatives that are being suggested as being part of the future. Is that correct?

Dr. GRONVALL. That is correct.

Mr. EDGAR. Thank you.

Ms. Kaptur, for a question.

Ms. KAPTUR. Thank you, Mr. Chairman.

Dr. Gronvall, you were here earlier I think when we questioning Congressman Oberstar——

Dr. GRONVALL. Yes.

Ms. KAPTUR [continuing]. And at that time we entered a discussion about partnership efforts that the VA has entered into with existing hospitals, and perhaps other health care providers. I wonder if you might be able to provide to me and for the record a summary of less than four pages of what the nature of those relationships have been and also with a focus on where we've been able to save money. Are you capable of doing that over there?

Dr. GRONVALL. Yes, we surely are.[1]

Ms. KAPTUR. OK, I don't like to ask you to do a lot of extra work.

Dr. GRONVALL. No, we'd be pleased to.

Ms. KAPTUR. And, divide it into an orientation in terms of policy, whether it's been done in relation to full hospital systems or satellite clinics or what types of health care. If you could put it in some organized fashion so I could see the direction, I'd be very interested in that?

Dr. GRONVALL. Be glad to. As I mentioned earlier, we do have some limitations in our authority to enter into contractual and sharing arrangements. But, within that we've moved in that direction and then we've had a remarkable expansion of our sharing arrangements with the military hospital system in the past several years and we could summarize that, I think, quite briefly for you. Be pleased to.

Ms. KAPTUR. Thank you very much.

Thank you, Mr. Chairman.

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[1] See p. 80.

Mr. EDGAR. Thank you.

Ms. Johnson.

Ms. JOHNSON. Thank you.

Dr. Gronvall, I'm sorry that I had to miss most of your testimony but I will catch up on it through my colleagues and staff.

I did want to ask you two questions.

First of all, you may be aware that at one time the Newington Veterans Hospital in Newington, CT, was at the top of the list for construction funds. That is no longer the case. On March 11 to 14 your people will be up in Connecticut doing an indepth survey and will soon propose a report on whether a new hospital should be built next to the University of Connecticut Medical Center in Farmington or whether the facility in Newington should be rehabilitated.

There are two things I'd like to ask of you. First of all, would you keep me closely informed as to the progress of that survey?

Dr. GRONVALL. Be pleased to.

Ms. JOHNSON. And, second, I'd like to know whether as part of that evaluation you will be considering the possibility of building the new tower at the University of Connecticut Health Center and rehabilitating the old Newington Hospital for a nursing home for veterans.

We've had a lot of testimony from people today about the number of veterans they represent and the average age of our veterans population now and in a decade. One of the things that's very clear from the data is that Connecticut has a lot of veterans and yet is 49th in terms of the benefit dollars that we get back from the VA. I believe we may be receiving very few of the benefits that our veterans are entitled to receive. There are a lot of reasons why this is so, and one is that the facilities are not appropriate to the veteran needs as the population ages and the demand for nursing home care increases. This is going to be an enormous problem and while it is something that I'm sure that you're aware of and concerned with, I wondered if you're considering at all the increasing need for of nursing home care for vets in Connecticut?

Dr. GRONVALL. I appreciate your comment and let me ask Mr. Falco to summarize what we're reviewing in Connecticut right now.

Mr. FALCO. We are considering the nursing home needs in Connecticut, as we are in all States, but our present plans for the Newington Hospital do not include adding another hospital to the system, so to speak. So, the decision will be based on the architectural solution and the cost associated with your total modernization in Newington or a relocation of Newington.

Ms. JOHNSON. That was my impression, too, frankly of the good of the current study. And I'm concerned about the possibility of inadequate long-term planning for elderly veterans in Connecticut, I foresee us creating a situation in which we must provide an enormous amount of reimbursement to the private sector. It seems to me that we ought to be considering whether or not it would be cheaper to refurbish a facility like Newington to provide our own long-term care in the decades ahead rather than providing that care through the private sector.

Dr. GRONVALL. As you may know, at the present time in regard to nursing home care, the Veterans' Administration itself meets only some 40 percent of the total nursing home needs of veterans that we've identified. Another 40 percent being met through the State Home Program and some 20 percent being met through contractual arrangements with community or private nursing homes.

As we've looked toward the future and projected the need it has appeared to us that the escalation of need is such that it is unlikely that under any circumstance the VA itself would meet all of that need and so our plans have really been for a kind of shared responsibility or partnership approach in which the private sector, the States, the State Home Program as well as the VA——

Ms. JOHNSON. Without question a partnership will be necessary and appropriate, but even to retain our 40 percent position, as the elderly population increases we will need some additional resources. The Newington facility is a sound facility structurally and may be more appropriate for a nursing home than for an acute care facility and while I know that cause has not been part of our study, I'd like to suggest reviewing that facility's use from the perspective of future demands for nursing home care. I don't think it's going to be reasonable or responsible to sell off old facilities or return them to States. I think we're going to need them in the future to retain our position of providing 40 percent of nursing home care for veterans in the next couple of decades.

I'd also like to ask what number or what percentage of the hospitals in the VA system are currently serving only veterans with service-connected illnesses. Now I recognize that the law does not restrict VA hospitals to serving only that population, but my experience is that many of our facilities are in practice of serving only that population. On the other hand my experience from a recent visit to Chicago, while not directly to a VA institution, but involving conversation with a lot of knowledgeable people, is that their VA hospital is serving mostly non-service-connected veterans.

I wonder, to what extent are you looking at the system's load from this perspective?

Dr. GRONVALL. We are certainly reviewing that. There is no hospital in the Veterans' Administration that serves only service connected. The proportion of service connected to nonservice connected of veterans served in each of our hospitals varies across the country based on demographic trends and availability of other health care, et cetera.

Ms. JOHNSON. I guess my point is that it varies from being very high, moderate or low. I am not sure how far down the spectrum it goes, but I know from my experience that it does reach near capacity levels.

Dr. GRONVALL. We have the data on the experience to date in our various hospitals on the proportion of service connected and I could supply that.

Ms. JOHNSON. I would be interested in that. Thank you.

Dr. GRONVALL. Yes, we also would want to take into account other mandated eligibilities as a part of our specifically mandated mission—care of ex-POW's, World War I veterans, Spanish American veterans. There are a number of additional special categories——

Ms. JOHNSON. Right.

Dr. GRONVALL [continuing]. To the service connected, and then we have our eligibility for non-service-connected at a lower priority. We would be pleased to supply that.[1]

Ms. JOHNSON. Thank you very much.

Mr. EDGAR. Thank you; the time of the gentlewoman has expired.

Mr. Mollohan from West Virginia.

Mr. MOLLOHAN. Thank you, Mr. Chairman.

Dr. Gronvall, could you explain to the committee on what basis and what criteria you use in reordering your construction priorities?

Dr. GRONVALL. I will make a brief comment and then others might expand on it, if you wish.

We are within a few weeks of submitting to the Congress a report on prioritization which will propose adoption of a new and significantly improved methodology for setting those priorities.

But, in brief, the way we have done this is to first draw together all of the projects in a specific category such as all nursing home projects, all major clinical additions or renovations, fire and safety projects, et cetera.

We then utilize a number of criteria in each of those categories to arrange the projects in priority order, taking into account patient care needs, the existing state of the facility, et cetera, et cetera, so that within each of those categories a rank ordering is created.

Then, all of those categories are collated into one overall prioritized list. And in the past, that has been the most difficult step for us where we have attempted to have a mix of projects such that each year we accomplish a balanced total program of construction so that we do not do all just nursing homes or all major projects in any one year.

The new proposal which you will see within a couple of weeks will give more rigor to that final step, and make clearer the objective as well as the professional judgement basis on which that final total list is submitted. But it is an attempt to start with priorities within individual categories and then combine those into a single rank ordered priority list for the entire construction proposal.

Mr. MOLLOHAN. Priorities that are listed 1 year, do they move through and maintain their priority position from year to year until they reach the top and then become constructed, or does it occur that the—what do you put on that priority list, 10?

Dr. GRONVALL. We are——

Mr. MOLLOHAN. I am just looking for a number.

Dr. GRONVALL. Yes. Ten.

Mr. MOLLOHAN. And do they get 10 last year, would they be the same 10 this year?

Dr. GRONVALL. Except for those who have been constructed and then they would be taken off?

Mr. MOLLOHAN. Yes.

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[1] See p. 74.

Dr. GRONVALL. With few exceptions, the list of 10 has continuity and, as a project gets built that is a higher priority, one of the others move up and new projects come on the lower part of the list.

There have been occasions where something fundamental has happened to cause us to reconfigure or revisit a project and then it may have moved off of the list of 10. But, as a generalization, they stay on the list until they get done.

Mr. MOLLOHAN. What is the amount of unobligated construction funds that you have on hand right now? Ms. Livingstone?

Ms. LIVINGSTONE. In the major construction program which is——

Mr. MOLLOHAN. Well, I want to break it down between major and minor in a minute.

Ms. LIVINGSTONE. OK.

Mr. MOLLOHAN. I guess I am looking for a total right now.

Ms. LIVINGSTONE. The unobligated balance at the end of fiscal year 1984 in the major program was $913.9 million, and in the minor program it was $203.8 million, which totals $1,117,737,000.

Mr. EDGAR. Would the gentleman yield at that point?

Mr. MOLLOHAN. Certainly, Mr. Chairman.

Mr. EDGAR. Are you certain that all of that billion dollars worth of unobligated funds is committed to projects that will, in fact, move toward construction?

Ms. LIVINGSTONE. They are committed to projects. Whether, again, given the bidding market, we will be utilizing full allotment remains to be seen until the awards are made.

Dr. GRONVALL. But the answer to your question is yes, all of those are on a track toward construction.

Mr. EDGAR. Thank you.

Mr. MOLLOHAN. Thank you.

Ms. LIVINGSTONE. Excuse me, let me ask Mr. Neumann to comment. Does that include the working reserve?

Mr. NEUMANN. That includes the working reserve.

Ms. LIVINGSTONE. Thank you.

Mr. NEUMANN. At the end of the year we pledged $160 million toward this budget.

Ms. LIVINGSTONE. So the unobligated figure that I read to you does include our working reserve which is the funds remaining after awards have come in already. That currently stands about $27 million, so those funds are not dedicated to specific projects. We will either use these moneys to fund cost increases on ongoing projects or to offset next year's budget request as we did this year.

Mr. MOLLOHAN. Do you have your design fund in place? Is that a realized goal? I know you all talked about that for a couple of years. Do we have a design fund and is it operating as you envisioned?

Ms. LIVINGSTONE. In the fiscal year 1985 appropriation $15 million was appropriated for initiation of the design fund, and those were for working drawing design of projects in our fiscal year 1986 budget.

To answer your question, yes, it is operational. The difficulty we face this year is, given the very late pass-back date from OMB, and the very intense negotiations that delayed our finalizing our

budget, those projects have not yet gone out for actual working drawing award yet.

Twenty-three of the 33 projects in our fiscal year 1986 budget will be utilizing design funds. The other 10, for one reason or another, such as the design being done in-house, or the replacement modernization projects which have prior year funding are not part of the design fund.

Mr. MOLLOHAN. I have an abiding interest in the Clarksburg addition, as the Veterans' Administration knows. And the slippage in that project has been particularly disappointing because it slipped at all and now because it has slipped so much. Last year I asked for a construction schedule and it was estimated that you would begin working drawings in October 1984 without the design fund.

Did you have a design fund at that time?

Ms. LIVINGSTONE. No, sir, we did not. We initially asked for a design fund in fiscal year 1984, which would have been funding design work on fiscal year 1985 projects such as Clarksburg. It was rescinded by Congress.

Mr. MOLLOHAN. I understand. And this is a schedule without design funds. Begin drawing, working drawings in October 1984, complete working drawings in July 1985. I am now advised that there is some slippage in that.

Can you enlighten me or confirm that?

Ms. LIVINGSTONE. Yes, sir. The working drawing contract was awarded on February 22, 1985. That is a delay. The reason is that the architect engineer firm on that job had never been audited before by the Federal Government.

So, when we built in our initial schedule, we did not add in the additional time that it required to make the audit.

In addition, the contract was above $1 million, and we had to go to the Department of Labor for an EEO clearance which takes additional time.

Mr. MOLLOHAN. And you mean in the original estimate, none of that was taken into consideration, the fact that it would be above $ million? I mean, it would be perfectly reasonable for me to assume, if I were in your position and looking down the road, that the working drawings would have to go to Labor.

Ms. LIVINGSTONE. We frequently cannot precisely determine how long other agencies are going to take to respond to our audit or EEO requests. For example, our audits are performed by the Defense Contract Audit Agency. They may do them very quickly; or they may take some time, depending on the work loads.

Our actual response from the Department of Labor on the EEO clearance did not come back until January of this year.

Mr. MOLLOHAN. Well, is it common practice that you do these audits on firms after they become interested in bidding when they are going to hold up major———

Ms. LIVINGSTONE. The audit———

Mr. MOLLOHAN [continuing]. Construction? Excuse me, let me ask the question.

Ms. LIVINGSTONE. I'm sorry.

Mr. MOLLOHAN. Particularly major construction projects. Should not we do our audits before they become—make that a criteria for

eligibility to bid instead of holding up these projects 1 year? And that is what it has done; you have slipped it 1 year here.

Ms. LIVINGSTONE. Let me just begin to comment and Mr. Fote can expand on that.

The audit itself is done on the actual negotiated price. And what DCAA reviews is the overhead, the profit, and the specific price negotiation for that specific contract.

Mr. MOLLOHAN. You mean every firm is audited on every project.

Ms. LIVINGSTONE. That is correct. I believe there are some provisions for waivers if they have had previous audits by the Federal Government within the last year. The contracting officer can make a determination that an audit is not required, but Mr. Fote can expand.

Mr. MOLLOHAN. Can you give me paper backup on each of these representations you have made, both on the audit and with regard to Labor, when the documents were sent to Labor, who processed them at Labor, when the documents were sent to whoever did the auditing, and who did that work, and when you received communication back from them?

Ms. LIVINGSTONE. I would be pleased to.[1]

Mr. EDGAR. The time of the gentleman has expired.

Mr. MOLLOHAN. Thank you, Mr. Chairman.

Mr. EDGAR. Mr. Staggers.

Mr. STAGGERS. Thank you, Mr. Chairman.

Doctor, I want to follow up a little bit with what Mr. Bilirakis had explored. The major difference that I understand, and correct me if I am wrong, that the 5-year plan for meeting the needs of the veterans is that it will have no expansion.

Dr. GRONVALL. No; let me correct that. The 5-year needs estimates that we have submitted in the past couple of years have not been constrained by the budget. At the present time, we are in deliberations with the Office of Management and Budget about the 5-year needs assessment that will be submitted this June 30.

I cannot tell you what decision will be made about the needs assessment to be submitted, but——

Mr. STAGGERS. The former past 5-year plans and the needs assessment, the major difference that we were looking at a 5-year plan with this budget would be that there will be no expansion?

Dr. GRONVALL. The 5-year needs assessment is submitted and then out of that, on a priority basis, projects are built into a budget for a specific budget request. The needs assessment is not a budget request.

In this particular budget, when we went back to last summer's needs assessment, translated that into this budget, the nonexpansionary policy was then built into the budgets so that projects from the previous needs assessment, which would have been expansionary, have been eliminated from the budget request.

Mr. STAGGERS. My point would be that looking at the needs assessment and not taking into the consideration of the freeze approach and not have an expansion will affect the needs.

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[1]See p. 82.

Dr. GRONVALL. It affects the accomplishment of new construction to meet the needs that were documented in the needs assessment, yes.

Mr. STAGGERS. Has anyone looked at what are the costs for the future if we do not have an expansion?

Dr. GRONVALL. Well, when you say cost, I want to be sure what you mean.

Mr. STAGGERS. Dollars and cents.

Dr. GRONVALL. Mr. Walters has testified several times that all of the outyear numbers in the 1986 budget, by agreement between the agency and the Office of Management and Budget, are plug numbers. I use a quote from Mr. Walters, and that the policy regarding the future of health care in the VA needs to be revisited this year in the administration and that the 1987 budget developed based on whatever the outcome of that policy review is, so that 1987 and the outyears will be new budgetary proposals to be developed.

So, my answer would be that the 1986 budget does not in its outyears project the cost of a new policy or a nonexpansionary policy or any policy. Those are soft numbers that will be redeveloped when the 1987 budget is submitted.

Mr. STAGGERS. So, in the past, we have had these 5-year plans and we have felt there was some need for expansion. This year we are changing policy and saying we are going to freeze, and if we are going to meet the needs Mr. Bilirakis was mentioning, if we are going to meet the needs of the veterans, if we do not do it this year, it is going to be more expensive in the future. Is that a safe assumption?

Dr. GRONVALL. Yes. If a project is done in a more distant year, the total cost of the project increases.

Mr. STAGGERS. Would it also be safe to say that if we do not meet the needs of the veterans this year and if we continue the policy which seems to be a changing policy that will freeze, that there will be additional pressure to basically do away with part of the system?

You mentioned that there was limitations on contracting out; the limitations are there for a purpose. Would not there be more pressure to continue to contract out and could that lead to a gutting of the VA health care system?

Dr. GRONVALL. That calls for a speculative response I think on my part, and I would say, yes, it is possible to describe a scenario of the sort you are describing where that could happen, yes.

Mr. STAGGERS. No further questions.

Mr. EDGAR. Thank you.

Mr. Ridge.

Mr. RIDGE. Thank you, Mr. Chairman.

Doctor, during your testimony when you were identifying the needs assessment, you talked about conversion of hospital beds to nursing home beds. And I do not recall the figure, but the conversion will involve 10,000 beds? Was there a figure specifically?

Dr. GRONVALL. Oh, I am sorry. The figure that I referred to was that the budget includes some $10 million which we will use for projects converting hospital beds to nursing home beds.

Mr. RIDGE. And that would affect approximately how many beds? The $10 million will, in effect, convert how many beds?

Dr. GRONVALL. In the 1986 budget, we have 284 beds proposed to be converted from hospital beds to nursing home beds.

Mr. RIDGE. And in your long range 5-year plan in terms of needs assessment, what do you project will be the amount of conversion over the next 5 years if acting today on what you project over the next 5 years? Based on a need or at least having finances to meet that need what would the number of beds be?

Dr. GRONVALL. Yes. This budget in 1986 and the outyears that are portrayed here to cumulates to—I will have to revise that question specifically.

Mr. RIDGE. All right.

Dr. GRONVALL. I could supply it. But it is on the order of several thousand beds are projected over this period of years.

Mr. RIDGE. The precise figure would be appreciated, but not important I guess. Maybe what I would like to inquire is what assumptions you would make given the anticipated growth or demand, these may be assumptions that we disagree upon, and what about the trebling of veterans who reach 65 years of age or older between now and approximately the year 2000? If we are going to triple the number of veterans and if we are going to have to fight budget constraints to preserve that 40 percent figure of those treated in VA facilities, why would we be converting. Will we not be creating a shortage in hospital beds in the future?

Dr. GRONVALL. Several comments. We have attempted, as we make our projections, to take into account a changing pattern of medical care needs as veterans age. It is clear that older veterans need acute hospital care and often need more of it than younger veterans.

But at the same time we have been able to improve the efficiency of our hospital treatment by being able to shorten the length of time a person needs to be in the hospital.

Therefore, with fewer operating hospital beds we are able to treat as many patients in the hospital. Said a different way, by shortening the stay we are able to free some hospital beds that then can be converted to nursing home beds to meet an expanding need for long-term care and nursing home care.

So, we have tried to take all of those factors and trends into account in making a projection that for the future we could see some tradeoff with conversion of hospital beds to nursing home beds and still provide a total balanced program that is geared to the needs as we best can project them.

Mr. RIDGE. In that written response dealing specifically with conversion, I would appreciate your thought, because in spite of the logic of your statement, just the incredibly expanded demand over the next 10 or 15 years, if it is, in fact, a tripling, if we do agree that there will be a doubling or a tripling and if we do agree about acute care facilities, there will be a greater demand because of the age of the veterans. In spite of that demand, how can we then start converting? and I would appreciate it if you would address that.

Dr. GRONVALL. Yes, I would make the same comment again that I have just made. That the outyears in this budget are soft, and so they do not reflect anybody's projection of what will actually be needed then in nursing homes.

Mr. RIDGE. All right. Changing gears just a little bit, does the VA have a stated policy or is it up to the discretion of the director of the medical facility or medical center to utilize equipment in the local communities and private hospitals? Are medical center directors encouraged to utilize private facilities and their technology before making a request to buy their own equipment?

Dr. GRONVALL. Yes.

Mr. RIDGE. I see my time is up.

Mr. EDGAR. The time of the gentleman has expired.

Mr. Kanjorski.

Mr. KANJORSKI. Thank you, Mr. Chairman.

Doctor, could you tell me the status of the Veterans' Administration hospital funding for rehabilitation in Wilkes-Barre, PA?

Dr. GRONVALL. If we cannot do that immediately, we would be glad to supply it. But, Mr. Falco, can you comment?

Mr. EDGAR. As far as I know, it is on track.

Dr. GRONVALL. Thank you, Mr. Chairman.

Mr. EDGAR. The last time I asked the question. Can someone answer Mr. Kanjorski? The Wilkes-Barre hospital, it's—I am guessing at how much in my head.

Dr. GRONVALL. Mr. Fote, can you comment?

Mr. Fote. Yes. It is presently being planned and worked up so it will be ready for the 1987 budget consideration.

Mr. EDGAR. Has that slipped at all?

Mr. FOTE. That I cannot say.

Mr. EDGAR. Mr. Kanjorski.

Mr. KANJORSKI. Well, is that part of what is going to be reevaluated with the Office of Management and Budget?

Dr. GRONVALL. During the current year, the policy regarding the future of health care will be revisted. The 1987 budget will be built on whatever comes out of that set of deliberations that will involve the Congress, of course. And, so, in that context, yes. But we continue our planning, of course, based on projects that are moving through the pipeline.

Mr. KANJORSKI. All right. Doctor, where you have impacted areas of large aging veterans such as Pennsylvania and northeastern Pennsylvania, are there any facilities that can be made available to utilize abandoned hospital space within the State system? In other words, the State of Pennsylvania owns a series of hospitals, and they are in the process of divesting themselves from those hospitals. And in many instances there are millions and millions of dollars of very expensive hospital care units in those hospitals.

Has the VA done any examination to see whether it would be worthwhile to acquire either for free or with little cost those hospital facilities to be utilized by the Federal system?

Dr. GRONVALL. Yes, we have been approached by a good many communities and investigated hospitals under exactly that circumstance.

I am going beyond your specific question, but as a generalization, of course, often the suggestions we have had relate to hospitals that are in areas where the VA already has a hospital that, in our judgment, is serving the need, but we regularly investigate such offers, yes.

Mr. KANJORSKI. Well, specifically in the instance of the Wilkes-Barre area, there are two hospitals that are being abandoned within a 6-mile radius. I am wondering whether it would be advisable to look at the efficiency of perhaps acquiring the entire institution that is being abandoned as opposed to building new facilities or adding on facilities.

Dr. GRONVALL. To my knowledge, that question has not been raised with us, unless someone recognizes it. But we would certainly be pleased to review that.

Mr. KANJORSKI. Should I direct that to the Administrator's attention?

Dr. GRONVALL. Yes, please do.

Mr. KANJORSKI. Thank you.

[Subsequently, the Veterans' Administration furnished the following information:]

The status of the Wilkes-Barre modernization project (693-026) is in the conceptual stage of development. The concepts will be completed by July 1985. It is anticipated that this project will be considered for inclusion in a future budget submission.

Mr. EDGAR. Would you also provide for Mr. Kanjorski and for myself an updated report on the Wilkes-Barre hospital?

Dr. GRONVALL. Yes.

Mr. EDGAR. And what the intention of the Veterans' Administration is to complete that project——

Dr. GRONVALL. Yes.

Mr. EDGAR [continuing]. In terms of years?

Dr. GRONVALL. Surely will.

Mr. EDGAR. Mr. Bryant, do you have any questions?

Mr. BRYANT. Doctor, in the course of putting together your budget requests, I am curious about the process. When do you begin gearing up for these hearings and for deciding what you are going to present to Congress as a budget request?

Dr. GRONVALL. I am tempted to say we never stop, but that is not the real answer.

We have planning that goes on in a multiyear cycle, really beginning at each individual medical center and it sits down and looks forward to its own needs based on the programs that the medical center is operating.

Each medical center then develops proposals for facility projects that would support the mission of the medical center.

Those are reviewed in collaboration with our MEDIPP planning process, which is basically a program planning process. The MEDIPP plans come into the central office after going through regional and district review, and are reviewed in central office. And when a program projection is approved, we also review the facility implications of that to be sure that we have planned for the facility needs.

Each year we compile all of those facility projections into the 5-year needs assessment which we submit on June 30. That document is our best judgement of everything that would be needed over the next 5 years.

That flows, then, into the budget development, the budget which is a translation of that into a specific request which goes to the Office of Management and Budget in September. It is reviewed

through the executive branch and released by the President in January or February and that we are now in deliberation.

So, the planning for the projects that are before us today was initiated, in most cases, some 2 or more years ago at the medical center level.

Mr. BRYANT. Now, when the—you forward that on to the Office of Management and Budget, did you get something back different than what you sent up there?

Dr. GRONVALL. Yes. The normal part of the process is that the agency makes its request, and then this year just before New Year's, we received a passback from OMB which established both some policy guidelines and constraints, as well as specific recommendations. We then engaged in active negotiation dialog between the agency and OMB, the result of which was the President's budget unveiled in early February.

Mr. BRYANT. Well, did they ask—I guess specifically I am curious as to what cuts and what you determined was necessary to serve the veterans were requested. If you could quantity it to some extent. What was the difference in what the OMB sent back and what you sent up?

Dr. GRONVALL. I cannot off the top of my head supply a gross figure in the construction budget of our request compared to the final budget submission.

Mr. Falco, can you, or can someone get that figure?

Ms. LIVINGSTONE. It was approximately $400 to $500 million. The difference is essentially at our needs assessment for fiscal year 1986 as compared to what the budget reads today.

Mr. BRYANT. Could you provide us with a list of the projects, construction projects or any other services that you had determined were necessary that are not going to be—that are not in your budget request today that were in it when it went to OMB?

Dr. GRONVALL. I think maybe we have already been asked that question, but I want to be sure that we respond specifically. That you are asking for all of those projects that were part of the agency submissions which are not now included in the 1986 budget.

Mr. BRYANT. Right.

Mr. EDGAR. That is correct.

Dr. GRONVALL. Yes.

Mr. EDGAR.—We are asking what are the projects included in the $400 to $500 million——

Dr. GRONVALL. Yes.

Mr. EDGAR [continuing]. That was deleted by Office of Management and Budget.

Dr. GRONVALL. Yes, we will be pleased to supply that for the record.

[Subsequently, the Veterans' Administration furnished the following information:]

PROJECTS IN VA OMB SUBMISSION WHICH ARE NOT INCLUDED IN THE FISCAL YEAR 1986 CONGRESSIONAL BUDGET SUBMISSION

REPLACEMENT AND MODERNIZATION

Allen Park, MI—Replacement and Modernization;
Atlanta, GA—Clinical Addition, Parking Garage, and Seismic Strengthening;
Augusta (Uptown Division), GA—Replacement Medical Center;

Dallas, TX—Clinical Addition, Renovate Building 2 and Spinal Cord Injury;
Gainesville, FL—Clinical Expansion and 290-Bed Psychiatric Building;
New York, NY—Outpatient and Clinical Addition and Alterations;
Pittsburgh, PA—Replacement Medical Center.

NURSING HOME CARE

Cheyenne, WY—120-Bed Nursing Home Care Unit;
Fort Wayne, IN—120-Bed Nursing Home Care Unit;
Marion, IN—240-Bed Nursing Home Care Unit;
Martinez, CA—120-Bed Nursing Home Care Unit;
N. Chicago, IL—120-Bed Nursing Home Care Unit;
St. Cloud, MN—120-Bed Nursing Home Care Unit.

RESEARCH AND EDUCATION

Omaha, NE—Education and Research Addition;
White River Junction, VT—Research and Education Addition.

OUTPATIENT IMPROVEMENTS

Montgomery AL—Outpatient Clinical Addition

CLINICAL IMPROVEMENTS

Beckley, WV—Clinical Addition and Alterations;
Perry Point, MD—Clinical Addition, Building 23H;
Salt Lake City, UT—30-Bed Spinal Cord Injury Center and Canteen;
Wilmington, DE—Clinical Addition.

GENERAL PROJECTS

Martinsburg, WV—Laundry Replacement;
W. Los Angeles, CA—Replacement Laundry.

REGIONAL OFFICE PROGRAM

Fargo, ND—Relocate Regional Office to Hospital Grounds;
Wichita, KS—Relocate Regional Office to Hospital Grounds.

Mr. BRYANT. Thank you.

Mr. EDGAR. Could we have a time on that submission?

Ms. LIVINGSTONE. As soon as we can get it cleared through OMB. [Laughter.]

Mr. EDGAR. By tax day.

Let me ask some questions. I know Chris Smith has—I'm sorry. Do you have additional questions?

Mr. BRYANT. No.

Mr. EDGAR. I apologize for that.

Let me ask some questions. We had some people here who are waiting to hear me talk about Philadelphia and because of my being late, I deliberately waited until now to raise those questions with you.

Can you tell me in the submission for Philadelphia you want to spend $12 million in fiscal year 1986, and you are going to build a 240-bed nursing home, which we are very pleased about; you are going to build some parking spaces next to the nursing home.

Can you tell me what the pedestrian bridge would be connected to?

Ms. LIVINGSTONE. The pedestrian bridge will be connected to the parking structure which is currently scheduled for funding in fiscal year 1987. The budget phasing of it, I agree with you, looks out of sync. However, the construction phasing provides for that structure

to be in place before they connect. The bridge will not just be left dangling cut in the middle of nowhere.

Mr. EDGAR. So, you are not just putting the bridge over the road and not having something at the other end.

Ms. LIVINGSTONE. No, sir. The construction schedule for the nursing home care unit is about 24 months, and I believe the parking structure is 10 to 12 months, so they will both overlap.

Mr. EDGAR. I guess I have a problem with that in light of what your legal counsel had said. And, that is, that you want to make sure that all contracts that you write include the full authorization. If I understand it, there is another $98,400 to complete the parking garage and make the renovations at the hospital and do the outpatient clinic. Is that not correct?

Ms. LIVINGSTONE. That is correct, but I believe the contract itself does not need to carry the full authorization. The contract needs to ensure that there is sufficient funds to cover the cost of that specific contract.

Mr. EDGAR. But your answer to that question gets me back to the answer of why you have to put $173 million or $190 million in for Houston if, in fact, you are not going to obligate it. And your answer to that question was you have got to have the full project in because you may obligate—you will obligate it in 1986 or 1987.

And here we have got a project on one side of the street, you are building a 240-bed nursing home, some parking facilities. And then you are going to put a bridge over, and in 1987 and 1988, you are going to connect that bridge to a parking garage and a renovation of the hospital and, hopefully, in 1987 you will come back and complete the outpatient clinic next to the nursing home.

Now, the question is, if you are going to be consistent, why did you not include the money for the parking garage and/or the renovation of the existing facility and/or the outpatient clinic in your budget submission this year for Philadelphia because your intention is that in 1987 you are going to have to obligate those funds anyway?

Ms. LIVINGSTONE. Yes, sir, that is correct, and I believe when the administrator appeared before you the other day, he indicated that we do have an agreement from OMB to complete the full funding for Philadelphia and Houston in fiscal year 1987.

The reason that $190 million was requested in fiscal year 1986 for the Houston project, although we cannot obligate the full amount, is the function usable unit theory again. We just did not want to leave a hole in the ground without having the financing to build the top of the structure and complete the building.

Whereas, in the case of Philadelphia, we have a completely functional, usable nursing home care unit, a functional 82-car parking lot, and albeit while the utilities cannot be hooked right into the parking structure until it is constructed, that part in the connecting bridge phase will not be difficult.

Mr. EDGAR. It seems to me if you look at logic there is a little inconsistency in the logic because I think what happens in our case is because our project is not a complete replacement hospital, it happens to be a moderization, we don't get the same priority. We have the same number of veterans, in fact, more outpatient needs than Houston does and the age of the hospitals are about the same,

Houston is moving toward replacement. And what you, in a sense, as an agency by doing it the way you are doing it is saying there is a higher priority in your minds to new construction of a full replacement hospital from the ground up because that is a unit. There will be 900 beds or however many beds you have in Houston. But because the Philadelphia project is not leveling its structure or putting a new replacement hospital up, but is putting very necessary nursing home beds, outpatient clinic, a very necessary parking facility and a very necessary renovation of the main structure of the hospital, that this could be viewed as three or four or five different units and phases. I am concerned about that because some of the older cities of the Northeast and Midwest have existing hospitals which we do not have the money in our budget to replace. So we have to utilize the segmented rehabilitation of the existing facility and some extended facilities on the side, and it looks a little bit askew when you look at the 1986 budget that your emphasis is on new construction and whole units, but that renovation does not have as much of a priority.

Ms. LIVINGSTONE. That was not the motivation in the fiscal year 1986 budget. Normally in the replacement modernization category, previous funding years have allowed us to receive the design funding one year and the full construction availability for the projects the following year.

This year we had a very stringent OMB passback in the replacement modernization category, and we had some very intense negotiations, basically trying to maximize those resources.

Philadelphia, Mountain Home, and Houston are all major priorities for the Department of Medicine and Surgery, and what we were attempting to do is ensure that with the money that was available to us, we got the best bang for the buck, as it were. The most construction possible for the money that was available, and that is why we phased these projects the way we did.

In the ideal world, we would have liked to have had full funding for all of them. However, we have commitments to complete that funding in fiscal year 1987, and the schedule delays are very minimal. A couple of months, I think, is the result.

Mr. EDGAR. Let me ask you a series of very specific questions. How much does it cost to build a 240-bed nursing home complete in Philadelphia?

Ms. LIVINGSTONE. I do not have the specific breakdown on that estimate. I do not know if Mr. Fote or Mr. Neumann have it. The Philadelphia nursing home breakdown.

Mr. FOTE. I think the breakdown was about $14 million if I remember, for the 240-bed.

Ms. LIVINGSTONE. Does that include the surface parking and the connecting utility?

Mr. FOTE. Yes, that amount——

Mr. EDGAR. Wait a minute. You are just asking for $12 million.

Mr. FOTE. We can explain that.

In 1985, we not only got design funds for the total project plus the phase I construction, and we have more money than we need for phase I construction and the total design.

So, it is a combination of the 1985 and 1986 funds which give us sufficient funds to do the phase II of the nursing home and the bridge and the surface parking.

Mr. EDGAR. How much would it cost to build the parking garage?

Mr. NEUMANN. About $10 million.

Mr. EDGAR. $10 million. How much does it cost to build the outpatient clinic?

Mr. NEUMANN. The remaining funds, whatever that——

Ms. LIVINGSTONE. About $90 million, I believe is close.

Mr. EDGAR. Wait a minute. If you build the parking garage and you spend the rest of the money on the outpatient clinic, then you build the nursing home, then you have no money left to build—to renovate the existing facility which is part of the project.

Ms. LIVINGSTONE. That dollar figure includes both the clinical addition and the renovation of existing structures.

Mr. EDGAR. I am asking the question what does it cost to build the outpatient clinic which is across the street from the existing facility.

Ms. LIVINGSTONE. I will ask Mr. Neumann to check. Can you break that out?

Mr. NEUMANN. My rough calculations suggest that it would be about $88 million if we went ahead and funded the parking garage now. We need $88 million to accomplish the rest of the program in Philadelphia.

Ms. LIVINGSTONE. But he is asking just for the clinical addition portion of that.

Mr. NEUMANN. That is what I am suggesting it would cost. The nursing home is now funded through our request in 1986. You were asking how much more for the parking garage. An additional $10 million, we have testified. We need about $88 million more, sir, to complete the project.

Mr. EDGAR. I guess what I am asking is if this committee, and there is some indication that this committee will accept the administration's numbers because we want to participate in deficit reduction, and that we will commit ourselves to spending the construction request which is $611.6 million; is that correct?

Now, if we approve that number, $611 million, and we go through the appropriations process and obligate you to spend money on the foundation of the Houston facility up to the first floor, phase I, the renovations and completion of the project at Mountain Home, and in Philadelphia the nursing home, limited parking next to the nursing home, pedestrian bridge, and complete the construction of the very necessary parking facility, holding off for an additional year the outpatient clinic and the renovations of the facility within that $611.6 million could you, in fact, complete all of that without drawing down on the funding necessary to complete those projects because you would have $180 million for Houston, you would have $22 million for Philadelphia, and you would have, in fact, all of the money necessary for the Mountain Home project.

Ms. LIVINGSTONE. But the funds are line itemed for each specific project. We could not draw off the unobligated balance on one project and transfer it to another project.

Mr. EDGAR. If the Appropriations Committee tells you to do that, you can do that.

Ms. LIVINGSTONE. Yes, sir, that is correct.

Mr. EDGAR. You are just making your recommendations and then we have to come back and make ours. And what I am suggesting to you is a recommendation that we might work for here might include an additional project in the Philadelphia facility, keeping our commitment to a completion of that facility in a timely fashion, not obligating or authorizing anything that cannot move from start to finish and live within the numbers that you have.

Ms. LIVINGSTONE. Indeed, if we were able to draw off unobligated balances on the other projects, that would be a feasible approach.

Mr. EDGAR. Thank you. I have other questions and I am under a great deal of pressure because members have to leave and we want to move toward our markup of some budget numbers for tomorrow's hearing. I will ask a few additional questions for the record and I ask unanimous consent that all members be given permission to offer their questions for the record.

Mr. Smith, do you have any questions at this time?

Mr. SMITH. No, Mr. Chairman.

Mr. EDGAR. Thank you. We really appreciate your testimony this morning. We are a little concerned that— well, we would just hope that in a timely fashion you could respond to our questions so that we can use some of that data in making our final determinations. We really appreciate your testimony.

Mr. SMITH. Will the gentleman yield?

Mr. EDGAR. I yield to the gentleman.

Mr. SMITH. Thank you, gentleman.

I have no questions at this point, but I would like to make a statement.

Mr. EDGAR. If the gentleman would yield just at this point. We will excuse the Veterans' Administration at this time.

Dr. GRONVALL. Thank you very much, Mr. Chairman.

Mr. EDGAR. The gentleman is recognized for his statement.

Mr. SMITH. Mr. Chairman, as you know and——

Mr. EDGAR. I am sorry. Let me interrupt you. I apologize. The gentleman from West Virginia does have some questions if the panel will stay. I apologize and thank you for speaking up.

Dr. GRONVALL. Thank you, Mr. Chairman, it is good to be back. [Laughter.]

Mr. EDGAR. Second round of hearing. Mr. Smith is recognized.

Mr. SMITH. Thank you, Mr. Chairman, later on today I am introducing important legislation to establish a Veterans' Administration satellite outpatient clinic in southern New Jersey. It is my hope that this subcommittee will give this project consideration. At the appropriate time, I hope to offer the language of the bill as an amendment to the VA authorization proposal.

For many years now, the VA has been aware of the vital need to establish such a facility to serve the nearly 1 million veterans in the State of New Jersey. Several approaches to solving the desperate need for additional health care facilities have been suggested but none to date have been established.

Veterans in the southern regions of New Jersey currently must travel either to the Philadelphia VA Hospital or to the Wilming-

ton, DE, Hospital. Veterans living in southern New Jersey often have serious difficulties gaining access to VA medical facilities. Of the two VA medical centers in the State, both are located in northern New Jersey and only one—East Orange—now has an operating surgical unit.

Mr. Chairman, past studies have shown that only 0.7 beds exist per 1,000 veterans. When compared with a nationwide average of 3.2 beds per 1,000 veterans, the need to expand health care services for New Jersey veterans is painfully apparent.

The VA's own planners in Medical District IV, which includes some 61 counties in New Jersey, Pennsylvania, Delaware, and Maryland, have confirmed the dire need to establish an outpatient clinic in the southern or central region of the State. The minimum threshold required by the VA to establish a satellite oupatient clinic is 15,000 service-connected visits per year. In Ocean County alone, Mr. Chairman the VA estimates that a satellite outpatient clinic would receive 52,000 visits by service-connected veterans per year. That is more than three times the minimum number of visits the VA has determined justifys the establishment of a satellite outpatient clinic.

The only other outpatient facility in New Jersey, located in Newark, is extremely busy and has been plagued with staffing shortages and equipment breakdowns. Even if the inaccessibility of this clinic to veterans in the southern region of the State were not a factor, the inability of this clinic to handle the demand for its services alone would merit the establishment of a new outpatient clinic.

As a member of this Subcommittee, I have carefully studied the recent VA Study, "Caring for the Older Veteran." This study predicted that by 1990, 7.2 million veterans will be over 65, doubling the total for 1980. These veterans will all be eligible for free medical care from the VA, a privilege they have rightfully earned by their service to this Nation. If we are unable to meet the current health needs of the nearly 1 million veterans in New Jersey, how will we deal with an even greater number of eligible veterans 10 or 15 years down the road?

In addition, Mr. Chairman, from a demographic perspective, the elderly population in New Jersey is growing at a tremendous rate. The introduction of casino gambling into Atlantic City and a number of other factors have led to a migration of older Americans to the State.

I am introducing this legislation when we go into session at noon today in an effort to not only meet the current unmet demand, but also to prepare for the future. The dollars we spend to establish a clinic in fiscal year 1986 will help tens of thousands of deserving veterans. Mr. Chairman, let me point out that this effort is truly bipartisan. Mr. Chairman I would like to include a letter to the VA endorsing this project signed by every member of our delegation.[1]

Mr. HAMMERSCHMIDT. Will the gentleman yield?

Mr. SMITH. I will be happy to yield.

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[1] See p. 83.

Mr. HAMMERSCHMIDT. I am aware of the long-time concern the gentleman has with the development of this project, and I want to support him in every way that I can to fulfill that.

Mr. SMITH. I thank the ranking member.

Mr. EDGAR. Thank you. Before yielding to Mr. Mollohan for final questions, let me move to the second part of our agenda and ask each Member to take a look quickly at a proposed recommendation which will be considered tomorrow in terms of some budget numbers.

You should have before you two sheets of paper, one of which includes the Subcommittee on Hospital and Health Care Proposed Recommendations on Fiscal Year 1986 Medical Care Budget, and the second Subcommittee of Hospitals and Health Care Nonlegislative Proposals, Fiscal Year 1986. Does everyone have both of those before them?

I yield to Mr. Mollohan for further questioning of our witnesses.

Mr. MOLLOHAN. Thank you, Mr. Chairman.

Dr. Gronvall, as I understand the Veterans' Administration procedure, and really my questions are designed to achieve a better understanding of your procedures, to assess and then finally recommend different facilities for inclusion in the VA system.

Could you outline for the committee what steps are gone through in order to, I suppose, identifying needs, settling on projects, and then prioritizing projects—hospital projects, nursing home projects, rehabilitation projects?

What is the process? Does all that come under the heading of MEDIPP planning? And to the extent that some of it does not come under MEDIPP planning, would you identify that also?

Dr. GRONVALL. You have asked a very broad question. Let me try, in a concise way to describe the process, and perhaps you will ask additional questions if you want elaboration.

The MEDIPP planning process is basically a program planning process by which each of our 28 districts review the current status of veterans' care in the district, reviews the data which we have developed about the demographic projections as to how many veterans will be in the district for future years, takes into account guidance given by the Central Office regarding national program priorities—focus on aging and things of that sort; and each district then prepares a plan through MEDIPP, which is a programmatic projection for the aggregates of medical programs that should go on in that district to best meet that need into the future.

Mr. MOLLOHAN. Do you identify that stage as something? What do you call that?

Dr. GRONVALL. It is a part of the flow of the MEDIPP process. Each MEDIPP cycle starts with guidance issued from the central office, then a local planning phase during which the district prepares its phase, then a submission, review and approval phase, which ultimately leads to decisions by the Administrator.

Mr. MOLLOHAN. OK; let me get to—are those identifiable steps?

Dr. GRONVALL. Yes.

Mr. MOLLOHAN. And would you please enumerate them, one by one for me?

Dr. GRONVALL. Let me turn to Mr. Gregg, who really works in that every day to describe the specific steps in that process.

Mr. MOLLOHAN. OK; let me just say this. Can you identify those stages, those steps? Are you capable of identifying them?

Dr. GRONVALL. Me, myself?

Mr. MOLLOHAN. Yes, sir.

Dr. GRONVALL. Yes.

Mr. MOLLOHAN. Would you please do that for me.

Dr. GRONVALL. OK.

Mr. MOLLOHAN. Identify the name of it. What do you call that? So I can get some kind of a handle of where we are.

Dr. GRONVALL. The whole process that I have described is the MEDIPP planning process. The first phase is issuance of guidance from the central office. The second phase is district planning within that guidance and based on demographic projections.

The third phase is district and regional review. The next stage is submission to the central office with——

Mr. MOLLOHAN. Excuse me—I'm sorry.

Dr. GRONVALL [continuing]. The next stage would be submission of the plans to the central office. The next stage is a consolidated central office review of all of the plans for the entire Nation; and the final phase is approval, which includes both Department of Medicine and Surgery approval, and in specific instances, Administrator approval.

Mr. MOLLOHAN. Do we commonly look at the MEDIPP planning process as a 5-year planning process?

Dr. GRONVALL. The horizon in MEDIPP is longer than 5 years. In the most recent cycle it was——

Mr. MOLLOHAN. Do you have any estimate on an average if it is possible to do this of how much time is dedicated guidance from the national office?

What kind of a process? Is that a year of planning process?

Dr. GRONVALL. No; that would be on the order of 3, 4, or 5 months, something like that.

Mr. MOLLOHAN. How about district planning? Do you have any timeframe?

Dr. GRONVALL. District planning would be another—about 3 or 4, or 5 months.

Mr. MOLLOHAN. What about district/regional review?

Dr. GRONVALL. A month to two months, I believe.

Mr. MOLLOHAN. And what about submission to the central office?

Dr. GRONVALL. That is just mailing it in.

Mr. MOLLOHAN. And what about consolidation at the national level?

Dr. GRONVALL. That takes from about November until January or February, so that is 2 to 3 or 4 months.

Mr. MOLLOHAN. And how about approval?

Dr. GRONVALL. And the final approval process, this would be 1 month to 2 months.

Mr. MOLLOHAN. So, if you had a project out there, it would be possible to get it approved within—approximately a year period?

Dr. GRONVALL. Yes.

Mr. MOLLOHAN. Then, what—when you talk about the process stretching out to 1995, what are you saying in light of these timeframes you have just given?

Dr. GRONVALL. That is the cycle during which each of our districts develops and projects all of its medical care programs from the current time out to 1995.

Mr. MOLLOHAN. And how does that factor into this timeframe? Is that done preceding the steps that you have enumerated? All of that field work, developing the demographics?

Is it based upon that information that the process that you have just described to me begins and proceeds and concludes its——

Dr. GRONVALL. Yes, the work on making demographic projections in a sense is a constant work going on in the Department.

Mr. MOLLOHAN. So, therefore, that precedes—that is the information, the data, based upon which this sixth step, MEDIPP process which you have described to me depends and upon which it is based?

Dr. GRONVALL. Well, that is the crucial part of the data; it is not the entire data base on which the process proceeds.

Mr. MOLLOHAN. Are there any exceptions to this procedure that you have outlined for me?

Dr. GRONVALL. There are occasions when a national priority is established. For example, through specific legislative action to initiate programs, and in such a case if there is a legislative mandate to initiate a program, we would develop a program.

Mr. MOLLOHAN. Is there any other circumstance in which this process would be circumvented or not followed?

Dr. GRONVALL. I am not aware of another circumstance in which long-term medical care programs get developed independent of this process.

Mr. EDGAR. Would the gentleman yield for a question at this point?

Mr. MOLLOHAN. Yes.

Mr. EDGAR. And I know he has a real important final question.

You do not know of any other times when that happens?

Dr. GRONVALL. Well, it depends on what kind of action you are talking about.

For example, if there is a disaster at a hospital——

Mr. EDGAR. No, I am not talking about disasters or emergencies. We are talking about under the regular process.

You would not just take a private citizen out there who makes the request and accelerate that to the top of the list?

Dr. GRONVALL. We get many such inquiries or suggestions and those are cycled into our planning process.

Mr. EDGAR. I yield back to the gentleman.

Mr. MOLLOHAN. Thank you, Mr. Chairman.

Are you the office that would evaluate these requests?

Dr. GRONVALL. When the requests come into the central office, the primary evaluating responsibility is in the Associate Deputy Chief Medical Director's Office.

Mr. MOLLOHAN. Are you familiar with Pruntytown, WV?

Dr. GRONVALL. Yes, in a general way.

Mr. MOLLOHAN. In what general way would you describe that you are familiar with Pruntytown?

Dr. GRONVALL. I did not have responsibility directly for the deliberation, but I have heard reports, and descriptions.

Mr. MOLLOHAN. Would you please relay to me, the committee, to what extent and in what way you are familiar with Pruntytown, WV?

Dr. GRONVALL. I heard reports through the period of time during which a suggestion had been made to the Veterans' Administration that a facility in Pruntytown might serve as a Veterans' Administration facility; that facility was visited; there were discussions between representatives of the VA and local people in Pruntytown and in West Virginia, which led to a conclusion that the State should develop and submit a proposal for development of a State home with Federal/State funding if the proposal is submitted, approved, and finally funded.

Mr. MOLLOHAN. Is it your Department, or whatever you call your office—would you have responsibility for monitoring and scheduling that request and putting it through the—perhaps if you would just enumerate for me.

Dr. GRONVALL. The specific responsibility for the State Home Program is in the Office of the Assistant Chief Medical Director for Geriatrics and Extended Care.

Mr. MOLLOHAN. Does that come under you?

Dr. GRONVALL. Not directly.

Mr. MOLLOHAN. Indirectly does it come under you?

Dr. GRONVALL. Yes.

Mr. MOLLOHAN. How?

Dr. GRONVALL. That office reports through the Associate Chief Medical Director to me and the Chief Medical Director.

Mr. MOLLOHAN. And then to whom do you report?

Dr. GRONVALL. I report to the Chief Medical Director.

Mr. MOLLOHAN. And to whom does the Chief Medical Director report?

Dr. GRONVALL. To the Deputy Administrator and the Administrator.

Mr. MOLLOHAN. Was that program, to your knowledge, handled outside of this, these processing steps that you have enumerated for the committee?

Dr. GRONVALL. The suggestion to us to review a——

Mr. MOLLOHAN. Excuse me. I do not mean to cut you off. Could you answer that question yes or no, and then elaborate, please?

Dr. GRONVALL. The review of the facility in Pruntytown was not part of the MEDIPP process.

Mr. MOLLOHAN. What process is that a part of?

Dr. GRONVALL. I do not know that that has a name. I had responded to an earlier question that we have had a number of inquiries or suggestions that there are facilities around the country that might serve as a Veterans' Administration facility.

Mr. MOLLOHAN. Excuse me. So, your answer to my original question is no. It was not processed in accordance with the normal operating procedures, is that correct?

Dr. GRONVALL. No; I could not say that this was not handled following a normal administrative procedure.

I believe I need a few more sentences to describe the relationship between such an ad hoc review of a proposal that comes from outside the Veterans' Administration with our MEDIPP planning process.

Mr. MOLLOHAN. OK.

Dr. GRONVALL. When we are contacted by a State or community to say, "Why don't you acquire *x* facility for a VA facility?" we often convene an ad hoc team to visit the facility and review it to see what it could serve for.

Mr. MOLLOHAN. You often respond to these requests in that manner?

Dr. GRONVALL. Yes.

Mr. MOLLOHAN. How long have you been with the Veterans' Administration?

Dr. GRONVALL. Slightly over 2 years.

Mr. MOLLOHAN. And could you identify other situations where that has occurred?

Dr. GRONVALL. Yes. During that time, we have had teams visit facilities in Alabama; and I believe, in Illinois.

Mr. MOLLOHAN. In the same timeframe?

Dr. GRONVALL. Yes.

Mr. MOLLOHAN. To what extent does the process that you have described, and this is the bottom line question I have, to what extent does that process have integrity? That is, is the process always followed? This process, this planning process that you have outlined for me. And, if not, please enumerate under what circumstances it is not.

Dr. GRONVALL. No identified process is rigidly followed in every instance. As I have already said, if there is a new national initiative, let's say that is established by legislation, that would not be planned through a grassroots district-based planning process.

The initiation, for example, of the Veterans' Outreach Program, readjustment counseling, came not as a result of grassroots planning, but as a national program established——

Mr. MOLLOHAN. No; that is different from what we are talking about, though.

Dr. GRONVALL. If I could add to the line that I was taking.

When we visit a facility to review an existing facility which is not now part of the Veterans' Administration, what we then do is turn to our MEDIPP planning process to acsess whether we have needs that have been planned in our program planning process, for which that facility might play a part in meeting the need.

Mr. MOLLOHAN. OK.

Dr. GRONVALL. And that is the point at which the ad hoc evaluation of such an offer is compared with what our own planning projections of what needs we have throughout the country.

Mr. MOLLOHAN. OK.

The chairman has indulged me way beyond my time, which I certainly appreciate.

Could I ask, Mr. Chairman, if the witness would submit for the record, obviously because his memory—I would not expect him to pull these instances out of his hat—where you have had these ad hoc requests, where you have responded to them, and enumerate for me in what timeframe within which they were responded.

Can you do that for the committee?

Dr. GRONVALL. Yes.

[Subsequently, the Veterans' Administration furnished the following information:]

There are a number of instances when a community hospital has been offered to the VA for purchase or as an outright gift for renovation as a VA owned and operated facility. Before the VA will seriously consider such an offer or will conduct an inspection of such a facility for possible VA use, the agency makes a determination of whether a need exists for expanded VA health care capacity in the geographic area under consideration. This determination is made through the Medical District Initiated Program Planning (MEDIPP) process. Frequently, the MEDIPP analysis will show there are sufficient existing VA facilities in the locale or the projections of the VA potential patient population are not sufficient to justify purchase of the offered community facility.

The following is a list of facilities that have been brought to the attention of the Veterans Administration as available for sale, where further investigation has seemed warranted. No facilities have been offered for lease or lease with option to buy, except as a part of normal leasing activities, i.e., warehouse space, day treatment centers, outreach clinics, satellite clinics, etc.

Facility	Location	Reviewed
Flowers Hospital	Dothan, AL	March 1984.
Providence Hospital	Mobile, AL	Do.
Mental Health Center	Galesburg, IL	July 1984.
West Virginia Industrial School for Boys	Pruntytown, WV	August 1984.
Maryland General Hospital	Baltimore, MD	July 1982.
Nuestra Senora De Los Angeles Hospital	Rio Piedras, PR	February 1983.
The following organizations have approached the VA and offered to build, build and lease, or build and operate nursing home care units, without specifying a specific location:		
National Health Care Affiliates	Building and operating	October 1983.
California Association of Health Facilities	do	February 1984.
Health Group Care Center, Inc.	Building only	March 1984.
American Health Care Association	Building to VA	Ongoing.

Mr. MOLLOHAN. Do you know who makes that decision in the final analysis? Who made it with regard to Prunty town?

Dr. GRONVALL. By final decision——

Mr. MOLLOHAN. Who made the decision to make the site visit?

Dr. GRONVALL. I do not know the answer to that.

Mr. MOLLOHAN. Thank you, Mr. Chairman.

Mr. EDGAR. I wonder if you would include for the record how many political requests you honor. That is, suppose the opponent of Chris Smith who was just here, a Republican, decided that Chris Smith was not working hard enough on his outpatient clinic for southern New Jersey, and he was able to find a site for an outpatient clinic, and he made the request of the VA that they bring their ad hoc team out in September of the election year to Chris Smith's district, and to look at that site with television cameras, and in a sense move it up in the planning process—and how many of those requests would you honor?

Dr. GRONVALL. I am sorry, but I really do not know how to answer that question.

Mr. EDGAR. I am asking a specific question of numbers that you can supply for the record, but let me ask a very specific question in relationship to Chris Smith.

Suppose Chris Smith's political opponent decided that Chris was not working hard enough on the southern New Jersey outpatient clinic and wanted, for political advantage to have the VA to come out to southern New Jersey to look at three or four additional sites, would the VA dispatch a team to that simply because that opponent of Chris Smith's decided that it was important to do.

Dr. GRONVALL. I think no, and in my experience, in every instance that I am aware of, where a request through the political system, or from a State, has come into the Veterans' Administration, there is at least a period of time during which there is discussion within the VA regarding the status of our programs in that area.

Do we have a need? We have had some instances where requests have come to us to investigate facilities in an area where our own data clearly show that there is no need, no unmet need existing, and our response then has been that it is not worth the effort to dispatch a team to review a facility in an area where we know we have no unmet need.

Those are few and far between, but have occurred.

So, there is a process of deliberation. I cannot really identify the specific—there is no single official who makes that decision or does not make it in every case. Each one is judged on its own merits, I think.

Mr. EDGAR. But if the VA, using its limited resources—they are very fragile resources—did, in fact, go out and visit in Chris Smith's district for the advantage of an opponent to Chris Smith, for political advantage, do you think that it would be appropriate for some political entity to pay that cost rather than the Federal Government?

Or do you think that there is a legitimate reason why the Federal Government should, in fact, honor the travel costs and expense that might be involved?

Dr. GRONVALL. I believe, Mr. Chairman, that you have really asked a question that is beyond my capability to answer.

I can reply at least, perhaps in a partially helpful way to say that the very strong guidance that we in the Department of Medicine and Surgery have operated under direct guidance from the Administrator, is that the deliberation about where and when we will build a facility to care for veterans is not a partisan political or political question, that we are to strictly proceed on the basis of professional judgments about need, or consider every possible opportunity that comes along, but that the VA should not become a ground for political advantage, and the Administrator has repeated that often.

Mr. EDGAR. Can you answer a specific question in relationship to the West Virginia project that my colleague is raising, and that is, can you in all good conscience say that no political consideration was made in the site visit in West Virginia?

Dr. GRONVALL. Yes, I can, because I know the people that went on the site visit, heard their report, and I do not believe that the judgment expressed in that site visit——

Mr. EDGAR. That is not the total part of my question.

Dr. GRONVALL. I am sorry.

Mr. EDGAR. The question is, can you in all good conscience say that the request for the site visit was not a political request?

Dr. GRONVALL. I cannot say that it was not. I do not know the answer.

Mr. EDGAR. Are there any additional questions? We must move on. We have one other witness.

Mr. MOLLOHAN. I know we have, Mr. Chairman, and I do appreciate your indulgence.

I would like to point out for the record—let's get it through the doctor. We do have a veterans' nursing home in West Virginia and that State-Federal relationship, do we not?

Dr. GRONVALL. I believe so, but I——

Mr. MOLLOHAN. Presently existing?

Mr. FALCO. Yes, there is.

Mr. MOLLOHAN. The answer of Mr. Falco was yes, there is?

And what is its occupancy in relation to its potential?

Mr. FALCO. I do not know.

Mr. MOLLOHAN. You do not know? We are going to have to get you up on West Virginia veterans and that particular facility.

There are professionals working at the Veterans' Administration, and, obviously, they feel awkward getting involved in political considerations.

I think we should, while we make these inquiries, applaud professionalism to the extent that it exists in the individuals; and I do, and I make that distinction.

Thank you, Mr. Chairman.

Mr. EDGAR. Thank you, and we really appreciate your answering that line of questioning, as well as the other lines of questioning, and we thank you again, Ms. Livingstone, for your first opportunity to testify before the committee.

We do have some additional questions for the record, and we have some additional statements for the record.

Without objection, they will be made in order.

I would like to call our final witness, who is David Gorman, assistant national legislative director for medical affairs, Disabled American Veterans.

Mr. Gorman, as you can tell, the hearing ran a little bit long and late, and we would appreciate any summary of your statement that you can make, if possible.

Without objection, your full statement will be made a part of the record.

STATEMENT OF DAVID W. GORMAN, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR FOR MEDICAL AFFAIRS, DISABLED AMERICAN VETERANS

Mr. GORMAN. Thank you very much, Mr. Chairman.

I would like to start off by saying that it is indeed a pleasure to appear before this subcommittee on the VA's fiscal year 1986 medical construction program.

As you know, Mr. Chairman, the VA's request for construction programs in fiscal year 1986 calls for budget authority of $611.6 million, of which approximately $553 million is devoted to the health care system.

Mr. Chairman, in our opinion, the delivery of quality health care to this Nation's veterans entails a commitment to modern, safe, and efficient medical care facilities.

To fulfill this commitment, it is necessary that the VA provide, on a continuing basis, for the reasonable expansion, renovation, modernization of its medical facilities.

When reviewing the VA's fiscal year budget for construction for medical programs, it becomes evident in our mind that the agency's ability to provide that quality care is being placed in jeopardy.

The DAV is concerned, as I know you are, Mr. Chairman, with how the VA will provide quality health care to the rapidly increasing aging veteran population.

We know that greater numbers of elderly veterans are seeking nursing home care from the VA; yet, of this budget, only 4.2 percent is requested for nursing home care bed requirements.

We are aware of and support the VA's proposal to convert 204 hospital beds to nursing home care beds.

However, this budget projects the loss of 1,000 operating hospital beds, which will bring the total loss of hospital beds within the system to 4,500 since 1981, while adding only 2,800 nursing home care beds to the system over the same period, or a net loss of 1,700 beds since 1981.

Mr. Chairman, in our view, the continued shutdown of beds within the VA is simply a waste of available resources; and we would encourage the VA to direct greater attention to the conversion of beds already closed, or to be closed, to nursing home care beds.

Mr. Chairman, although not a direct part of the VA's construction budget request, I would like to discuss the grants for the State extended care facilities.

The VA's budget request for fiscal year 1986 for grants of this nature is $22 million, a dramatic decrease of $12.5 million from the fiscal year 1985 level.

This request will provide for an additional 450 nursing home beds, as well as 126 convertible domiciliary or nursing home care beds.

Recognizing the significance and the important role of the state veterans' homes, in terms of care provided to the rapidly aging veteran population and the cost-effective use of Federal taxpayer dollars that supplement this program, we believe that it is shortsighted to cut funds in a program that ultimately produce savings to the Government in terms of both construction and health care costs.

Mr. Chairman, earlier, I discussed the aging veterans and the demands they will shortly place on the system. In our view the VA is faced with a second "aging challenge," that of its medical care facilities.

In the DAV's opinion, the capital plant of the VA health care system is deteriorating and will continue to do so at a rapid pace, due to what we consider to be underfunding over a long period of time for needed and necessary renovations.

As veterans grow older, their need for medical care becomes greater at more frequent intervals, and the complexities of treatment grow more costly.

Likewise, the condition of VA health care facilities cannot escape from the effects of age.

Mr. Chairman, again, I would like to thank the subcommittee for the invitation to appear before you today, and that concludes my testimony.

[The prepared statement of Mr. Gorman appears on p. 84.]

Mr. EDGAR. Thank you very much for your complete statement. The Disabled American Veterans were before us only a week ago and gave a more complete statement of other veterans' concerns, and we appreciate that.

Mr. EDGAR. I have no questions at this time.

Do either of my colleagues have questions?

Thank you very much.

The final witness will be the American Health Care Association, Julie Trocchio, director of delivery of service, American Health Care Association.

I appreciate your patience this morning, and I appreciate your coming.

Will you introduce your associate. Your full statement will be made a part of the record.

Ms. TROCCHIO. I certainly will.

STATEMENT OF JULIE TROCCHIO, DIRECTOR OF DELIVERY OF SERVICE, AMERICAN HEALTH CARE ASSOCIATION, ACCOMPANIED BY CHERYL BEVERSDORF, DIRECTOR OF LEGISLATIVE AFFAIRS, AMERICAN HEALTH CARE ASSOCIATION

Ms. TROCCHIO. Mr. Chairman, I am substituting today for Jenean Erickson, who, along with other people in the Twin Cities, is snowed in.

In addition to outpatient facilities, they probably need some extra snow removal equipment.

With me is Cheryl Beversdorf, and she is director of legislative affairs with American Health Care Association. We ask if you will please accept Jenean Erickson's statement for the record.

The American Health Care Association represents about 8,000 nursing homes throughout the country. We would like to see greater use of community nursing homes by the Veterans' Administration.

The record will show that a number of studies have recommended that the Veterans' Administration look at local community needs before determining if a nursing home is needed in a certain area.

We think that this would lead to a greater use of community nursing homes.

Now, the Veterans' Administration is a very valuable long-term care program. We would not like to see community nursing homes substitute for this. We would suggest, however, that you take a look at what community nursing homes are doing now.

Let me describe for you for 1 minute what the community nursing home program is.

The Veterans' Administration Hospital will contract with a local nursing home to provide care for a few veterans at a time. VA staff come; they inspect our nursing homes; they negotiate a rate with that nursing home for care of those veterans.

We think this is a successful program, in a couple of ways: First of all, providers benefit in this ongoing relationship with the Veterans' Administration. They have professionals who come, consult, and give direct information to our providers, on how to care for that individual veteran.

In addition, we think the Veterans' Administration is pleased with this program. The Veterans' Administration has told us that they are pleased with the quality of care, and it is very important to know that quality care is provided by the community nursing homes.

Finally, we think that the veterans are pleased with this program. They are able to live closer to their homes. They are able to live in a male/female environment, as opposed to primarily male, and they enjoy the community nursing home program.

Two facts I would like to bring to your attention right now. One is it costs community nursing homes approximately one-half of what it costs the Veterans' Administration to build a long-term care facility.

It also costs approximately one-half for the community nursing home to provide daily care than it does for the Veterans' Administration.

And these are the Veterans' Administration's own figures.

I would like to suggest some other options. One is that there be some private construction of nursing homes, which the VA could lease for its own use. This is not being done at the present time.

Next, we would like to see some private construction of a nursing home which the VA could lease and then contract out to management and staff of the facility for care of veterans.

In this sort of situation, the private facilities would build and the VA would contract out to care for these veterans.

Also, I would like to suggest leasing by the Veterans' Administration of existing private nursing homes; and contracting by the Veterans' Administration of a floor or a wing of a private facility, instead of just a few patients at a time, as I described before.

Finally, we would like to see a negotiation of different reimbursement systems, with payment made according to skilled care requirements.

For example, community nursing homes would develop special units with special reimbursement rates to care for veterans with more acute needs, such as those with spinal cord injuries, and those who are respirator dependent.

Right now, this is not done. It is one rate that is negotiated.

In the past year we have talked to a number of veterans' organizations and have shared some of these ideas with them. We, of course, are in constant communication with the Veterans' Administration.

Just in summary, we would like to say that we do think that there has been documentation that the Veterans' Administration has not always looked at local needs, or additional community nursing homes. Could they substitute in place of Veterans' Administration building themselves?

We want to work in partnership with the Veterans' Administration, and we would like to see them use the community facilities, as much as possible. Now, I welcome any of your questions.

[The full statement of Ms. Erickson appears on p. 91.]

Mr. EVANS [presiding]. Thank you.

Do you have any opinion why the Grace Commission would recommend that the VA should cease all construction of their own nursing homes and contract all this care to the private sector?

From your testimony, the GAO has on two occasions indicated that the VA should expand its contract nursing home capability with the private sector, and yet the VA budget reflects no increase for funding for contract nursing home program, and no new initiatives for cooperative agreements with the private sector to accomplish this goal.

Ms. TROCCHIO. We were very surprised that the budget does not include an expansion of the community nursing home program.

We were under the impression that the Veterans' Administration planned to continue its 40/40/20—40 percent contract nursing home, 40 percent care for veterans through its own program, and 20 percent through its State home programs.

We were frankly surprised that there was not an increase as there was in additional construction.

Mr. EVANS. Contract nursing beds are usually limited to a 6-months period, while VA nursing beds have no such limitation. Does this not change the issue somewhat in terms of what VA policy in the future ought to be in regard to building or contracting out?

Ms. TROCCHIO. The non-service connected veterans—and there is a limitation to 6 months in a contract nursing home program.

However, in reality that is usually much less.

We have found in the last few years that Veterans' Administration contracts seem to be 3 months, or sometimes even less, because of some budget conflicts.

If we would like—we would like to see some of the Veterans' Administration contract for some very special needs veterans, veterans perhaps on ventilators, veterans with spinal cord injuries.

We would like to see on a demonstration basis perhaps the 6-month limit dropped for those special care need veterans.

Mr. EVANS. I had a question in regard to per diem, calculations by the VA, but we will have to submit that, I guess, in writing, because I think all the VA people have left.

I appreciate your testimony. I appreciate your filling in for your associate today who could not make it here.

Ms. TROCCHIO. Thank you. She was sorry she could not be here.

Mr. EVANS. Thank you.

Having no witnesses in front of us, I guess that concludes the hearing.

[Whereupon, at 12 noon, the hearing was concluded.]

APPENDIX

STATEMENT OF JOHN F. SOMMER, JR., DEPUTY DIRECTOR
NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION
TO THE SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS AFFAIRS
HOUSE OF REPRESENTATIVES
MARCH 5, 1985

Mr. Chairman and Members of the Subcommittee

The American Legion is appreciative of this opportunity to present its views on the Veterans Administration medical construction program for Fiscal Year 1986, and related matters.

In the Administration's Budget proposal for VA, the medical construction program is recommended for a reduction of $154.9 million down to $712.9 million, for FY 1986. And that figure includes $160 million in prior budget authority that is being reprogrammed from the major working reserve.

We realize this is the second largest construction budget in VA's history, the largest being in the current fiscal year. However, we question the wisdom of reducing the funding for medical construction when the capital plant of the VA health care system is deteriorating. The reasons for this deterioration are manifold; one of them being serious underfunding of this program for several years until recently. This means VA is playing catch-up with its capital plant renovation and replacement program. The facilities have aged more while nothing was being done, and costs have escalated. It has been a losing proposition all around. Finally, the Government has been trying to make up for lost time, and it is costing a lot of money, but it is still a good investment. As we have said many times, the capital plant of the VA system is a multi-billion

dollar investment by the Federal Government, and it must not be allowed to deteriorate.

We have preliminarily reviewed the replacement and renovation projects scheduled for FY 1986, and based on the reports of our Field Representatives who make site visits to all of these facilities, we can assure the Subcommittee all of the work scheduled is needed, and much of it is long overdue.

We are pleased to see funding provided for work on a clinical addition, renovation, parking and a 240-bed Nursing Home Care Unit in Philadelphia; and for replacement and modernization at the VAMC Houston.

A significant amount of the construction funds proposed in the FY 86 budget will allow for elimination of health and safety concerns within several VA medical centers. Electrical improvement, asbestos abatement, seismic renovations, and fire and safety concerns require vast amounts of money to correct each year. Deficiencies cited by Joint Commission on Accreditation of Hospitals, National Fire Protection Association, OSHA, and National Bureau of Standards plague the deteriorating physical plant of the VA health care system. Elimination of these deficiencies is mandatory, and in many cases, the VA is legally obliged to correct them.

Although it is not under consideration by the Subcommittee at this time, The American Legion would like to voice its support for the proposed (FY 1987) 625-bed medical center in Palm Beach County, Florida. Reports also indicate that a new 240-bed Nursing Home Care Unit is proposed to be constructed simultaneously with the

hospital. The number of veterans migrating to Florida is increasing daily, and demographics certainly demonstrate the need for this facility.

In light of the projections concerning aging veterans and their future need for extended health care, The American Legion is concerned that the FY 1986 Budget only identifies construction of two 120-bed nursing homes to be located at Tucson, Arizona and Amarillo, Texas. If the anticipated influx of veterans over age 65 into the VA system materializes there is no way VA will be prepared to provide adequate care to these veterans without a significant increase in nursing home construction in the next three budget years. Although VA is attempting to develop cooperative efforts with community nursing homes, problems such as inadequate numbers of beds and limited resources are being identified. In the VA's report, "Caring for the Older Veteran," this is well documented. What is needed now is a concise action plan outlining the need for construction of long term care facilities and the date on which this construction will commence. Without buildings and beds, the best laid plans for future health care provisions are meaningless.

We do have two particular areas of concern we wish to mention. First is the issue of the replacement hospital at Baltimore. The need for a replacement hospital in Baltimore has long been established, and, in fact, construction had begun when the President included the funding for the construction in a recession message in 1981.

In August 1984 VA requested a $2 million increase in the Advance Planning Fund in the FY 1985 Budget request for use in determining the most appropriate approach to modernizing the medical centers at Loch Raven and Fort Howard. As a result of that request,

Congress provided the $2 million and directed VA to add the alternative of a new replacement medical center to the modernization of the two facilities. A planning report on this is scheduled for completion on April 1, and it will reportedly recommend the best course of action. Regardless of the recommendations contained in the report, we have been told that implementation of any proposals would not be possible until FY 1988 or 1989.

The American Legion strongly recommends a replacement hospital in Baltimore. We have seen evidence where veterans who could have benefitted from inpatient treatment at VAMC Baltimore, have been placed in ambulatory care programs in order to meet, as well as possible, their medical needs. We understand that the medical center has been forced to admit only those veterans suffering from the most severe acute illnesses, for which hospitalization is absolutely necessary. In addition, we have learned that due to constraints on resources and space, major elective surgery cases have been delayed.

An American Legion Field Representative conducted a regularly scheduled survey of VAMC Baltimore during the period of December 10-14, 1984. The following are excerpts from the Field Rep's observations as described in the site visit report:

" The physical plant, while kept relatively neat and clean, is literally bulging at the seams. The admission, screening, and outpatient clinic area is cramped and totally inadequate. Space to enlarge the pharmacy had to be carved out of the main lobby. The wards are congested, and there is poor traffic flow. The bedrooms are too small. Consequently, it is difficult to get emergency equipment into the far side of the two-bed rooms. There are also two-bed rooms with only one oxygen and suction panel.

"The temperature control within the bed areas was described as horrible. Patient areas become excessively hot or cold. In part,

this is due to the old windows, which are scheduled to be replaced. In part, this is also due to a two pipe system which allows hot or cold water to be sent into the system but not both. Thus, the system can not readily be adjusted for temperature variations. A project to put a computer control on the system is planned. This will hold fairly well until a decision is made concerning the installation of a four piped system, which is a major project.

"There is inadequate storage space in the hospital. Consequently, equipment is often in the hallways. This can present fire and safety hazards. Office space is at a premium. Rooms are often shared by several people. Another example of the congestion is the use of the clean utility rooms as multipurpose rooms. They are used for storage, meetings and conferences, as well as a place for students because there is not sufficient space for these various functions.

"In general, obvious space deficiencies are clearly discernible to any visitor. The deficiencies, which affect the delivery of care and the development of patient care programs, are well recognized. The continuing question remains: What solution will be used to resolve the problems, and when?

"The basic issues of the inadequacy of the present physical plant as well as the lack of necessary resources - funds, equipment, and personnel - for patient care have remained relatively unchanged since the last visit in May 1982. The physical plant is overtaxed. There simply is not sufficient nor efficient space in a 1950's structure oriented towards the treatment of tuberculosis patients for the state-of-the-art technology and treatment programs of a 1980's tertiary care facility.

"Currently, this medical center is operating at a 82 percent occupancy level. When the census gets above this level, it is difficult to support. Since very sick patients are being seen, the acuity of patients' illnesses must be taken into consideration in determining the supportable workload. Severe resource constraints in personnel, dollars and space have resulted in the artificial constraints of the inpatient census. This is so quality care can be maintained. This must be taken into consideration when evaluating the medical center's workload and in projecting its needs. Several "big ticket" pieces of equipment have recently been received or approved; however, there is a lack of dollars for items in the $30-$50,000 range and for smaller necessary items. While there have been some resource gains in the past couple of years, the reason the basic issues have not been resolved is because a decision still has not been reached regarding the delivery of health care in the Baltimore area.

"The medical center has submitted data regarding the inpatient Bed Model Projections in the 1984 MEDIPP submission stating that the estimates for VAMC Baltimore are inadequate for the future tertiary care needs of Maryland veterans. A total of 388 beds are projected as needed. This was derived by comparing VAMC Baltimore's workload and staffing statistics with similar VAMCs who have comparable veteran populations, and comparable outpatient demands.

"A decision regarding the construction plans needs to be reached reasonably soon or the COS fears that physicians will be leaving out of frustration.

The following information is contained in the conclusion of the site visit report:

"The current facility at Loch Raven is totally inadequate for the provision of quality patient care. This is no revelation. Virtually every visitor who has seen this station, and every evaluation and study conducted regarding the conditions at the station have acknowledged that something needs to be done. The hospital was not built to provide the kinds of service now mandated by its mission and by state-of-the-art medicine. The building is old and outmoded, and it is unbelievably congested. This is readily recognized, and it seems to be universally accepted. A list of deficiencies are readily available. What to do about the situation, however, is a question that has not been resolved. Congress has ordered a report due in April 1985 regarding the options of modernizing existing facilities or building a replacement hospital taking into account the needs of Maryland veterans. A recent extension of one year has been granted to the land originally designated as the site for the replacement hospital in downtown Baltimore.

"The issue of what decision will be reached regarding the delivery of health care in the Baltimore area has been confronting this facility for numerous years now. The plans for the replacement construction were approved in 1976 and rescinded in early 1981. During that timeframe, investments in this facility were deferred in anticipation of the replacement hospital. This made sense. Why spend dollars on a facility when the needed structure, technology and programs were planned within the new hospital. However, with the recision of the authority to build a new hospital came the ever widening gap between the allocated resources and the necessary resources to maintain the quality and up-to-date care. Resources had been deferred for years, but the facility was expected to continue providing services until another decision was reached. While recent efforts have been made to address some of the resource needs of this station, they must be considered nominal in terms of what is needed and what would have been received if a given construction program had been adopted. This facility has submitted its extensive short-term needs for continued operation during the interim period between whatever decision is made and the time the project(s) would be activated. Over one hundred FTEE and millions of dollars of replacement and additional equipment have been identified. This hospital has been in limbo for numerous years, and its baseline needs should be addressed.

"The indecision and fluctuating climate for the choice of the most appropriate alternative of health care delivery have taken their toll in terms of patient care and program development. In conversations with top management and Chiefs of Services it was reported

that resource constraints in personnel, dollars, and space have resulted in an artifically constrained inpatient census. The demand for services has been suppressed so that quality care can be provided within the available resources. The Director stated that the hospital can function at approximately an 82 percent occupancy rate. Above this, there is not sufficient nurse staff support. There are several recognized areas where program support is well warranted. Most notably this is in orthopedic surgery and rehabilitation medicine services (RMS). The orthopedic surgery program is being supported by volunteer faculty time, while the RMS program is extremely underdeveloped for the number and complexity of patients requiring these services. RMS support is received from VAMC Fort Howard, but it is neither as intense nor immediate as required by the patient population (those with acute strokes, or vascular surgery). As previously recommended in the last site visit, The American Legion supports the development of a Rehabilitation Medicine Service at this facility. It is recognized that this can only be accomplished in conjunction with construction for additional space.

"There has been some discussion about the bedsizing for this facility. A bed letter has been submitted by the station regarding the 1984 MEDIPP submission. The bed estimates for VAMC Baltimore were considered inadequate and justification was submitted for a proposal of 388 beds. A replacement hospital would provide the resolution of existing VAMC deficiencies in a facility oriented towards modern medicine and technology while requiring the least disruption of ongoing service. If there is a decision not to build a replacement hosptial then substantial and extensive investment will be needed in the present facility if it is to be adequately maintained. It is envisioned that if there is no replacement hospital, a clinical addition to house clinical activities and a three phase renovation of the existing structure will be required. While it has been mentioned that there are a plethora of deficiencies within the current physical structure, particular attention needs to be paid to the telephone system. This is a source of numerous veterans' complaints, and it can be readily addressed. A proposal has been submitted to VACO to modernize the switches and to add FTS lines and additional extensions. Support for the quick resolution of this nagging problem should be provided.

"Almost as important as which decision is made regarding major construction and the delivery of health care is the fact that some decision must be made. This station can not remain in an indefinite state of limbo. It affects employee morale, but most importantly it delays the access of Maryland veterans to a higher quality of care which could be established for them at this VAMC. The VAMC has access to quality health care providers via it affiliation, yet they are confined to operating in second-rate accommodations. The needs of the VAMC must be addressed to enhance patient treatment and program development for the benefit of those veterans seeking treatment here."

Mr. Chairman, The American Legion feels that a replacement hospital needs to be built and should be built.

Our second concern is the 60-bed nursing home that was proposed for construction at VAMC Providence, Rhode Island. At the request of the Chairman, Subcommittee on HUD - Independent Agencies, Senate Committee on Appropriations, the General Accounting Office issued a report dated May 15, 1984, subject of which is titled "VA Justification for Two Nursing Home Care Construction Projects in its Fiscal Year 1985 Budget Request." The report states that the project at Providence VAMC does not appear to be needed. The report goes on to say the VA did not adequately consider local needs and resources which indicate that the Providence area will have an ample supply of community and State Home beds to meet veterans nursing home needs in 1990. According to the report, on May 11, 1984, the Acting Chief Medical Director advised GAO that he had recommended to the Administrator that the project be deleted from the VA's Fiscal Year 1985 Budget request.

The American Legion disagrees categorically with the information released by the General Accounting Office that the VA assessment of the need for nursing care at Providence was not sustainable. We have been in frequent communication with the Rhode Island American Legion, and our information from that organization is contrary to the GAO Report.

A site visit report by an American Legion Field Representative covering the period September 5-11, 1984, states in its conclusions that the needs of the aging veteran have been brushed

aside by the Providence VA Medical Center. The report goes on to say that "the nursing home needs of the veterans within the Primary Service Area (PSA) of the medical center cannot be met today. If a 60-bed NHCU was opened today on facility grounds, it would be at full occupancy within a month. During the course of this survey, 55 veterans were placed in 28 contract nursing homes from this facility. This did not include 30 placements from the New Bedford area. Also, the waiting list was estimated at between 20-25. Exact figures regarding the waiting list were not revealed to this surveyor." The report continues by stating that no further placement could be done at that time because there was no funding available since it was the end of the fiscal year. The waiting period for veterans was reported by VA staff as only two to three weeks, but the Commandant of the Bristol State Home stated his waiting list included approximately 60 applicants and the waiting period was between six to eight months. The surveyor felt as a result that the figures offered by the VA staff were suspect.

Statistics from DM&S show that in FY 1983, 22,340 veterans resided within the Providence PSA between ages 65-74, and 6,886 were age 75 and older. It is estimated in FY 1990, 39,749 veterans will be between the ages of 65-74, and 10,824 will be age 75 or older.

Figures obtained from the Rhode Island Department of Health and used by GAO in support of its report reflect that providers plan to develop 1,098 additional nursing beds within the next five years whether through expansion or new construction. The Providence Medical Center Director advised our Field Representative that

it is certain that by the Spring of 1985, 432 additional beds will become operational and quite likely that 120 more beds will be developed by late 1985. It must be pointed out that if in fact the proposed 552 beds were constructed in the private sector, they would be for use of all citizens of Rhode Island, not just veterans. However, we seriously question the proposed number of beds, and particularly those proposed for 1985. As of September 1, 1984, the date on which our Field Representative left Providence, not one construction project had started within the State.

Recommendation No.1 contained in the Field Service Report recommends that funding for construction of a 60-bed NHCU be approved, and that the project be given top priority.

Mr. Chairman, on the basis of the Field Service Report and the information provided to us by the Rhode Island American Legion, we wish to reiterate at this time the support of the National Organization of The American Legion for the construction of a Nursing Home Care Unit at VAMC Providence. We are satisfied the unit is needed to provide care for veterans in the Primary Service Area of that VAMC. We believe the data assembled by the General Accounting Office is not accurate or correct, and does not demonstrate an understanding of the needs and problems of the aging veteran population of the Providence area. Our recommendation to the Subcommittee is that funding for the unit be enclosed in the FY 1986 Budget.

In summary, we would like to reiterate our concern regarding the wisdom of the proposed reduction in medical construction funding at a time when VA is playing catch-up with its capital plant renovation program.

As we have previously stated to the Subcommittee, in a sense the expenditures in this budget area are capital investments, and should not even be included in the total Federal funding that is leading to such high deficits. There is a school of thought in the Congress itself that the capital investment and expenditures of the Federal Government should be identified separately as they are in most business operations.

Mr. Chairman, The American Legion appreciates this opportunity to present our views on these extremely important matters.

AMVETS

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NATIONAL LEGISLATIVE DIRECTOR

February 28, 1985

The Honorable Bob Edgar
U. S. House of Representatives
Chairman, Subcommittee on Hospitals
and Health Care of the HVAC
335 Cannon House Office Building
Washington, D. C. 20515

Dear Mr. Chairman:

AMVETS appreciates the opportunity to present its views regarding the Fiscal Year 1986 VA medical construction authorization request. Because of conflicting schedules, we will not be able to appear on 5 March 1985 to testify on this subject. We request, however, that this letter be included in the record of the proceedings.

The Fiscal Year 1986 Budget for VA medical construction, despite the impending dramatic rise in the aging veteran population, is down from last year by $157 million. The Budget proposes a losing trade-off of 1,100 hospital and domiciliary beds for an increase of 700 nursing home beds. This is going in exactly the opposite direction from that in which we should be going if we are to avoid scandalous construction costs in the coming years as a result of allowing an aging and decaying plant to deteriorate without repair or replacement.

Of course, if this Budget is viewed from the perspective of the report of the Grace Commission and the philosophy of the Heritage Foundation, upon which the general VA Budget proposals appear to have been based, the failure to meet the challenge of caring for our aging veterans by maintaining an adequate medical construction program is entirely consistent.

AMVETS subscribes to the authoritative views of the former Chief Medical Director, Dr. Donald L. Custis, when he told the Senate Veterans' Affairs Committee on 20 February 1985:

> The proposed FY '86 budget not only would freeze V.A. medical care at the FY '85 level, but also reduce the construction budget by more than fifty percent of projected need, funding only certain projects with outlays already committed.
>
> It had been previously determined that just to replace the system's antiquated hospitals and maintain its plant facilities at the current size would require a one billion dollar (in constant '85 dollars) construction budget for the next ten years. The proposed FY '87 and FY '88 figures continue

The Honorable Bob Edgar
U. S. House of Representatives

to ignore that reality. Implication of intended future policy is also to be found in the FY '86 guidance that construction projects in the out year should be sized soley upon service-connected demographic need. This is consistent with the Administration's limitation of nursing home construction to two 120-bed facilities in FY '86, a reduction of 720 beds from the level requested.

In the Summer of 1980 and again in 1984, President Reagan appeared before veterans organization conventions and solemnly promised that regardless of economic restraints, America's veterans would not be forsaken. So far, it doesn't look like this promise is being kept.

Sincerely,

DAVID J. PASSAMANECK
Lt. Col., USA, Ret.
National Legislative Director

DJP/aimc

STATEMENT OF HON. J.J PICKLE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

I thank you for allowing me to appear before your Committee today. Although I have never had the pleasure of serving with you on this panel I have long-standing interests in veterans affairs by virtue of the fact that I have nearly 63,000 veterans in my District.

And, it is because of my concern for these vets that I come before your Committee today. My veterans currently travel over 100 miles round-trip to San Antonio, Texas or over 200 miles to Temple, Texas for medical care. This includes the aged veterans—and I have over 500 World War I vets in my District—and the infirm who must travel this distance when the need arises for the medical care provided by the Veterans Administration.

In was notified last Steptember (1984) that the VA had approved an outpatient clinic for Austin, Texas and that the VA had approved on outpatient clinic for Austin, Texas and that the VA begin studying work load estimates and space requirements. I have maintained contact with the Office of Facility Planning at the VA since that time, and was recently informed that the VA projects an estimated 33,000 visits per year at the clinic approved to be established in Austin.

Demand for VA outpatient medical services has been proven by the VA study. And, we can only expect demand to increase as the city continues to grow and the veteran population continues to age.

It is because of the expressed and proven demand for these services that I am concerned as to why the Veterans Administration did not include the Austin outpatient clinic in its FY 86 budget request. I am mindful of existing budget constraints, and am aware that all VA projects have to compete for funding. I also know that the veterans in my District need an outpatient clinic, and the VA has substantiated this point.

I have been making and pushing this point since 1982. The VA has approved the proposal submitted by the District Medical Office in Texas, the VA continues to evaluate space to be included in the budget.

I ask the consideration of this Committee for the outpatient clinic that the VA has approved for Austin, and make myself available to any questions you might have now or at a later time.

I thank you again, Mr. Chairman, for allowing me to appear before you today.

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STATEMENT OF HON. BILL NELSON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

It is my pleasure to join you here today to discuss future Veterans Administration medical projects.

It was a privilege to have this Subcommittee visit my District in September 1983, for a field hearing on the VA health care delivery system. It was at that time that I and many Central Floridians stressed our concern about the future of VA medical care in East Central Florida. Today, I would like to reiterate my support for the construction of a new hospital in Central Florida.

For the past five years, I have worked with the Veterans Administration to ensure that Central Florida veterans receive the highest quality medical care possible. At my request, Administrator Cleland inspected the Orlando Outpatient Clinic in 1979 and immediately initiated a program to double its capacity. However, despite its expansion, the extraordinary number of veterans moving to Florida and requiring medical service has already overloaded that facility.

The veterans population in Florida in 1980 was over 1.3 million. In 1990, it is projected to be almost 1.6 million. And the number of veterans age 65 or older is expected to increase by 41.2 percent by that date. Florida is one of only two areas in the Nation where the veterans population is projected to increase, while the national veterans population is decreasing.

To meet the medical needs of Florida veterans we must responsibly plan for adequate facilities. The Administrator's "Thirty Year Study of the Needs of Veterans in Florida" recognized the critical nature of the VA health care shortage in Florida. The "Final Report on Future Bed Need and Potential Sites for New VA Hospitals in Florida" identified East Cental Florida as a priority site for a new hospital. And importantly, this decision was based on careful, professional analysis of veterans' needs in that area, and not on political considerations.

Subsequently, Administrator Walters endorsed the recommendation of the VA's Medical District Initiated Program Planning Report for the "establishment of a new 470-bed VA Medical Center in the Brevard Primary Service Area." For your interest, that area includes all of my Congressional District, as well as five other counties in East Central Florida. The 1995 projected veterans population in those nine counties alone is over 277,000.

So you see, this project has the necessary Administrative support. It has the support of our area veterans organizations, as you well know from the testimony received back in 1983. And the needs expressed to you at that time have intensified by further overcrowding of existing facilities.

I appreciate this opportunity today to share with you my personal concern about the future of VA medical care in Central Florida. There is a tremendous need for this new proposed VA medical facility in East Central Florida. I urge your Subcommittee to carefully consider the overwhelming statistics supporting the construction of the hospital, as well as the strong community support.

The veterans of Central Florida urgently need your help. And I would personally appreciate your favorable consideration of this project.

STATEMENT OF HON. JAMES L. OBERSTAR, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WISCONSIN

I am here this morning on behalf of the compensable veterans of my District and the adjoining area of Northwestern Wisconsin who currently are required to travel up to 300 miles to receive care in a Veterans Administration Medical Center.

Minnesota veterans now travel to Medical Centers located in Fargo, North Dakota, and in St. Cloud and Minneapolis, Minnesota. Wisconsin veterans are served at St. Cloud or Minneapolis or at Medical Centers located in Milwaukee, Madison, or Tomah. Veterans who lack adequate health insurance coverage or who are otherwise unable to pay for private care are frequently required to take two days off work, one for travel and the second for care. If an early morning appointment is scheduled or a full day of clinic appointments is anticipated, it is often necessary to arrive a day early and the expense of a motel is added to lost wages. As a result of distance and unreimbursed costs, many veterans entitled to care and in need of care put it off until there is a medical crisis. Their treatment will then be provided by local hospitals and physicians with the Veterans Administration paying for that care because it is medical emergency. This is neither good medicine nor good economics.

There are 61,500 veterans living in the Duluth-Superior area. The nearest Medical Center is Minneapolis, 150 miles away. Some Northwestern Minnesota veterans travel twice that distance.

The Duluth-Superior area is still suffering a severe economic recession. Unemployment remains well above the national average. As a result of the decline in the United States steel industry, mines are shut down which may never reopen. Exports through the Port of Duluth-Superior are drastically down because of our trade deficit and the strength of the U.S. dollar. Employer sponsored health insurance protection, in many instances, has been cut back or totally lost. For numerous veterans with service-connected disabilities, there is no longer an alternative. They must either go without care or travel hundreds of miles.

This problem is not unique to Minnesota, but of all the nationally identified sites in need of satellite outpatient clinics, the Veterans Administration itself has ranked the Duluth-Superior area first. MEDIPP '83 for Medical District 18 identified an outpatient clinic for Duluth-Superior area as its top priority for approval and advance planning funding in Fiscal Year 1986. The need is now and it is critical. Twenty-thousand outpatient visits are projected as necessary to meet the medical and mental health needs of veterans living in the Duluth-Superior service area. Establishment of this clinic would not only remove the burden of travel for veterans who are sometimes too disabled or ill to travel, it would relieve overburdening in existing facilities and permit them to better serve their remaining patient population.

A 20,000 square foot space would be required for the projected 20,000 annual visits to the clinic. Renovation costs, if an existing facility is leased, are estimated to be $300,000. Property costs, including major clinic and diagnostic equipment is expected to cost $2.3 million. Staffing, including clinical, administrative and support personnel will require 43 full time equivalent positions. The clinic's annual recurring cost is estimated to be $1.7 million in 1984 dollars.

Community leaders and veterans groups strongly saupport immediate action and are anxious to work with the Medical District in the hope of identifying existing facilities which the Veterans Administration might acquire and renovate to meet its needs. Approval and advance planning authority this year will permit the Medical District to survey these facilities, select a site, and work with medical and civic groups to bring this project to reality at the earliest possible date.

I urge my colleague to approve this project so that planning can begin.

STATEMENT OF ROLF A. SHEPARD, DIRECTOR, KERN COUNTY VETERANS SERVICE DEPARTMENT

Mr. Chairman and members of the Subcommittee, thank you very much for this opportunity to testify today on an outpatient clinic for Bakersfield, California.

I am the County Veterans Service Officer and, as such I assist veterans their dependents and their survivors to obtain those Veterans Administration benefits to which they are entitled. I hear their complaints and problems. By far the most pressing need today is for accessible VA medical facilities.

To understand the nature of the problem it is necessary to note Bakersfield's location. It is approximately equidistant from Fresno VA Medical center to the North and Sepulveda VA Medical Center to the South, a distance of over 91 miles. It is located at the Southern end of the San Joaquin Valley and is surrounded on three sides by mountains. In the Winter the mountain passes are sometimes closed by snow or mud slides. Travel to the North is frequently impeded by dense fog. This makes travel to existing VA facilities difficult, if not impossible.

In addition to weather barriers, the veteran seeking VA medical help must cope with inadequate public transportation or frightening traffic conditions. None of the buses serving this area go directly to VA medical facilities and none are wheel chair accessible. Transfers to municipal transit systems are required. Many veterans are no longer able to drive and their spouses refuse to drive on Los Angeles freeways, so they are effectively denied their entitlement to VA health care. My office provides what transportation it can by a weekly van to West Los Angeles VA Medical Center. Last year we transported 465. We have more apply than we can take. We give priority to aged and seriously disabled but we cannot take wheelchairs or patients requiring oxygen to get over the mountains.

I would like to cite just two cases which happened in recent months which demonstrate our urgent need for a local VA outpatient clinic. The first is a veteran who is 100% service connected for a heart condition. He experienced severe chest pain and went to a local emergency room. The E.R. doctor called Sepulveda VA Medical

Center and was told not to admit the patient but to have him come to the VA Hospital. The doctor asked for the VA to provide an ambulance but the VA doctor said he couldn't accept the responsibility. Since the VA would not authorize his local admission or send an ambulance, the veteran was sent back home. Fortunately the veteran survived the episode.

The second case concerns a veteran who had been hospitalized for circulatory a problem in his leg at the Fresno VA Medical Center. He was sent home on February 4, 1985 with his leg wrapped and given pain medication. On February 6, 1985, his wife called and asked for more pain medication. She also said the leg seemed discolored and smelled bad. The doctor said he couldn't authorize any more medication and that the veteran should be placed in a convalescent facility. By Friday, February 8, 1985, the leg was black and the veteran was in severe pain. His wife called Fresno again but was told that the VA couldn't help him. She took him to a local doctor who had him admitted to a hospital in Bakersfield and his leg was amputated. Now the family faces a large medical bill.

These are just two of many cases where a Bakersfield VA Outpatient Clinic could have prevented needless pain and anxiety. Many of our service connected veterans have to make trips to the VA Medical Centers only to get prescriptions refilled. If a local clinic was in place the VA could save sizable travel funds.

I feel a VA Outpatient Clinic could be established at a reasonable cost in Bakersfield as there are a number of existing buildings that are a number of existing buildings that are suitable for conversion to an outpatient clinic. They are available for lease or purchase. Several contractors have also indicated a willingness to build to suit VA needs if an all new facility is desired. Some of the sites are adjacent to existing medical facilities that could provide contract services if desired.

Bakersfield is one of the fastest growing cities in the United States and has a sizable veterans population. Our weather and the low cost of housing in relation to other Southern California population centers make it a popular retirement area.

The City and County Governments both support the establishment of a VA Outpatient Clinic here. The local Medical Society is also in favor of such a facility.

Bakersfield is over 90 miles from the nearest VA medical facility. Our population exceeds the 150,000 population requirement and over 20,000 patient visits per year are anticipated. In short, all the elements required and necessary to justify a Veterans Administration Outpatient Clinic exist in Bakersfield and I urge your favorable consideration to establishing such a clinic this coming fiscal year. Thank you.

STATEMENT OF HON. WILLIAM M. THOMAS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. Chairman and members of the Subcommittee, thank you very much for the opportunity to testify today on a health matter of great urgency for veterans in my district. There is a grave need for a veterans outpatient clinic to be established to serve patients in Kern County, California, who are now effectively isolated from receiving regular and timely health care through the Veterans Administration.

This need has been recognized for many years, both by veterans organizations and by the Veterans Administration. At present, veterans living in Kern County must travel either 94 miles over a 4,000-foot mountain pass to Sepulveda for health care or 100 miles to Fresno. In winter, the pass is frequently closed by snow, and the route to Fresno is often hampered by dense fog which makes driving very hazardous. The V.A. minimum distance for outpatient clinics from veterans hospitals is 40 miles.

Kern County also far exceeds the population criteria for locating an outpatient clinic, with a Standard Metropolitan Statistical Area population of 440,000, nearly triple the V.A. minimum. About 50,000 of this population are veterans who would generate nearly 20,000 clinic visits per year, according to a lower V.A. estimate or more than 27,000 visits by a higher V.A. estimate. These estimates far exceed the V.A. minimum criteria of 15,000 annual visits, and they do not include probable visits from residents of southern Tulare and Kings Counties and southern Inyo County.

In addition, the community of Bakersfield has six hospitals available for support services and health care. The Kern County Medical Society has expressed its full support for locating an outpatient clinic in Bakersfield.

The final and most important reason to establish an outpatient-clinic in Bakersfield is our veterans' compelling need for health care. According to studies by V.A. Medical District 26 in California, 53.4% of Kern County's disabled veterans who visit the Sepulveda hospital are service-connected; the average for southern Califor-

nia is 41.8%. Kern County veterans average only .3 health care visits per veteran, half the national average of .6 visits. In addition, the income and education levels of Kern County veterans fall lower than average, which V.A. medical planners also state is an indication of V.A. health care need.

Another indicator of increasing health care need for Kern County veterans is age. Although the veteran population in Kern County is expected to decrease slightly in coming decades, the number of veterans 65 years and older in Kern County will nearly triple by the year 2000.

The profile emerging from all of these statistics shows a veteran populace with greater than average need for V.A. care, but who actually receive only half the national average of V.A. health care because these veterans live too far away from the nearest V.A. facility and can ill afford to travel the distances required to receive the care they need.

Having established the seriousness of the need, the question arises: How and when can the need be met? V.A. Medical District 26 in California has completed a preliminary study which states:

"The Medical District 26 District Executive Council and Planning Board consider the Bakersfield OPC a very high priority action that will remedy the problems of underservice to Kern County veterans . . . Given expeditious review and approval by VACO, we would hope to open the Bakersfield clinic at the latest by 1987."

Mr. Chairman, although fiscal year 1987 is the latest date recommended by the V.A. study for opening an outpatient clinic in Bakersfield, I believe that several factors weigh in favor of authorizing a 1986 opening. Congress has stated that its first priority in veterans health care is serving those with service-connected disabilities, and Kern County veterans would fit this category. The primary recipients of health care from an outpatient-clinic in Bakersfield would be service-connected veterans with a high percentage of elderly patients.

In addition, the outpatient clinic being planned for Bakersfield would not require constructing a new building, only leasing and altering an existing structure. At a time of limited resources for new V.A. construction, this alternative would require minimal budget outlays.

Mr. Chairman, local support for a clinic is unanimous. The Kern County Board of Supervisors and Kern County Grand Jury have notified the Chairman of the house Veterans Affairs Committee of the need for the clinic. More than 15,000 local residents, 6,000 of them veterans, have sent the Committee a petition seeking the clinic, and local health care administrators have offered their support and assistance in establishing the clinic.

A detailed analysis of the Bakersfield clinic is undergoing approval by the Veterans Administration. I would expect to have the benefit of this latest study within two months, and I will forward it to the Subcommittee. Mr. Chairman, I urge members of the Subcommittee to consider allocating funds in the 1986 V.A. health care budget to enable the Veterans Administration to begin establishing a clinic in Bakersfield. The need is clear and pressing, and the remedy is long overdue. I thank members of the Subcommittee for their consideration.

STATEMENT BY JOHN A. GRONVALL, M.D., DEPUTY CHIEF MEDICAL DIRECTOR

Mr. Chairman and members of the subcommittee, I am pleased to appear before you this morning to present testimony concerning the Department of Medicine and Surgery's medical facility construction request for FY 1986. The VA health care system is made up of 172 medical centers, 116 nursing home care units, 16 domiciliaries and 53 independent and satellite outpatient clinics. This system operates in a substantial physical plant with over 5,000 separate buildings whose ages range from the turn of the century to very recent construction. These facilities require a commitment to a capital investment program which preserves and protects the capital plant and provides improvements to keep pace with modern, state of the art medical care. The health care system must also respond to the changing needs of the aging veteran population. This construction budget proposal reflects this needed continuing commitment to meeting the facility needs of a modern, comprehensive health care delivery system to provide for our Nation's veterans.

The total dollar amount of the VA medical construction budget for FY 1986 is $722,893,000. This amount includes an appropriation request for a major construction program of $577,200,000. This includes $160 million that is available from previous appropriations. Of this total program level, $574,700,000 is for medical projects. We are requesting approval for funding of 31 major projects, $19 million for the advance planning fund to develop future year projects, $35 million for asbestos abate-

ment, and $20 million for the design fund. We are requesting funding to initiate construction of a major replacement facility of 927 hospital and 120 nursing home beds at Houston, replacement of all patient buildings at Mountain Home, and phase II, the 240-bed nursing home care unit portion of a major modernization project at Philadelphia. Subsequent construction phases of the Philadelphia project will include a new clinical addition, renovation of beds, a parking structure and correction of fire and safety deficiencies. In addition, this budget request includes two new 120-bed nursing homes, two replacement domiciliaries, two clinical improvement projects, three electrical improvement projects, seven fire and safety improvement projects, ten general projects, and two seismic correction projects.

Our minor construction program request is for a total of $194,400,000, of which $148,193,000 is for the construction of medical related projects. There are approximately 250 projects ranging in cost from $100,000 to $2 million which will be funded from this request. Included in this request is $10 million for the conversion of hospital beds to nursing beds.

The FY 1986 construction budget request has grown out of the planning and development efforts of the VA's planning process, including medical district initiated program planning (Medipp), medical center facility plans, and the five year medical facility construction needs assessment. These specific projects have been developed through the advance planning fund process.

Mr. Chairman, I would be pleased to answer any questions that you or the other members may have.

Number and Percent of Veteran Patients in VA Medical Centers

The numbers and percent of veteran patients in the VA medical centers are taken from the 1984 Annual Patient Census File. The information is based on discharge files of patients in the hospital on September 30, 1984. Patients classified as POW's are not included in the counts for Service-Connected, Pension, or Non-Service Connected.

TABLE OF STNAME BY CNP84REC

[CNP84REC C&P status; in frequency and percent]

Row	Medical center	Service connected	Pension	Non-service connected	Prisoners of war	Total
0030	Albany	109	34	323	2	468
		23.29	7.26	69.02	0.43	
0040	Albuquerque	112	48	101	0	261
		42.91	18.39	38.70	0.00	
0050	Alexandria	64	82	95	5	246
		26.02	33.33	38.62	2.03	
0060	Allen Park	130	59	219	0	408
		31.86	14.46	53.68	0.00	
0070	Altoona	22	30	30	3	85
		25.88	35.29	35.29	3.53	
0080	Amarillo	30	26	32	0	88
		34.09	29.55	36.36	0.00	
0090	American LA	142	41	142	0	325
		43.69	12.62	43.69	0.00	
0100	Ann Arbor	61	0	168	0	229
		26.64	0.00	73.36	0.00	
0110	Asheville	121	134	119	7	381
		31.76	35.17	31.23	1.84	
0120	Augusta	60	72	121	5	258
		23.26	27.91	46.90	1.94	
0121	Augusta Len	216	96	178	3	493
		43.81	19.47	36.11	0.61	
0130	Baltimore	42	30	120	1	193
		21.76	15.54	62.18	0.52	
0140	Batavia	20	42	99	2	163
		12.27	25.77	60.74	1.23	
0150	Bath	49	60	85	1	195
		25.13	30.77	43.59	0.51	
0160	Battle Creek	288	123	341	1	753

TABLE OF STNAME BY CNP84REC—Continued

[CNP84REC C&P status; in frequency and percent]

Row	Medical center	Service connected	Pension	Non-service connected	Prisoners of war	Total
		38.25	16.33	45.29	0.13	
0170	Bay Pines	169	47	156	4	376
		44.95	12.50	41.49	1.06	
0180	Beckley	28	49	55	0	132
		21.21	37.12	41.67	0.00	
0190	Bedford	282	96	284	1	663
		42.53	14.48	42.84	0.15	
0200	Big Springs	37	94	12	1	144
		25.69	65.28	8.33	0.69	
0210	Biloxi	64	97	79	2	242
		26.45	40.08	32.64	0.83	
0211	Biloxi Gulf	143	78	91	6	318
		44.97	24.53	28.62	1.89	
0220	Birmingham	78	40	124	1	243
		32.10	16.46	51.03	0.41	
0230	Boise	30	19	61	1	111
		27.03	17.12	54.95	0.90	
0240	Bonham	19	23	24	0	66
		28.79	34.85	36.36	0.00	
0250	Boston	182	79	250	2	513
		35.48	15.40	48.73	0.39	
0270	Brockton	237	114	288	3	642
		36.92	17.76	44.86	0.47	
0271	West Roxbury	55	0	101	3	159
		34.59	0.00	63.52	1.89	
0280	Bronx	66	34	290	0	390
		16.92	8.72	74.36	0.00	
0290	Brooklyn	173	33	363	0	569
		30.40	5.80	63.80	0.00	
0291	Brooklyn St	25	21	31	0	77
		32.47	27.27	40.26	0.00	
0310	Buffalo	140	36	465	0	641
		21.84	5.62	72.54	0.00	
0320	Butler	42	43	122	5	212
		19.81	20.28	57.55	2.36	
0330	Canandaigua	279	220	309	1	809
		34.49	27.19	38.20	0.12	
0340	Castle Point	42	33	98	1	174
		24.14	18.97	56.32	0.57	
0350	Charleston	28	22	147	1	198
		14.14	11.11	74.24	0.51	
0360	Cheyenne	24	2	65	0	91
		26.37	2.20	71.43	0.00	
0370	Chicago Lake	26	30	244	0	300
		8.67	10.00	81.33	0.00	
0380	Chicago West	54	3	295	1	353
		15.30	0.85	83.57	0.28	
0390	Chillicothe	283	96	263	1	643
		44.01	14.93	40.90	0.16	
0400	Cincinnati	63	45	132	3	243
		25.93	18.52	54.32	1.23	
0410	Clarksburg	42	40	81	0	163
		25.77	24.54	49.69	0.00	
0420	Cleveland	40	43	192	0	275
		14.55	15.64	69.82	0.00	
0421	Cleveland B	176	64	252	0	492
		35.77	13.01	51.22	0.00	
0440	Coatesville	270	72	547	0	889
		30.37	8.10	61.53	0.00	
0450	Columbia	45	36	147	3	231
		19.48	15.58	63.64	1.30	

TABLE OF STNAME BY CNP84REC—Continued

[CNP84REC C&P status; in frequency and percent]

Row	Medical center	Service connected	Pension	Non-service connected	Prisoners of war	Total
0460	Columbia	68	50	210	1	329
		20.67	15.20	63.83	0.30	
0480	Dallas	143	87	271	1	502
		28.49	17.33	53.98	0.20	
0490	Danville	142	167	305	5	619
		22.94	26.98	49.27	0.81	
0500	Dayton	79	29	283	4	395
		20.00	7.34	71.65	1.01	
0510	Decatur	148	69	159	2	378
		39.15	18.25	42.06	0.53	
0520	Denver	83	30	104	0	217
		38.25	13.82	47.93	0.00	
0530	Des Moines	36	17	101	4	158
		22.78	10.76	63.92	2.53	
0540	Dublin	52	95	97	3	247
		21.05	38.46	39.27	1.21	
0550	Durham	95	64	147	1	307
		30.94	20.85	47.88	0.33	
0560	East Orange	170	420	5	0	595
		28.57	70.59	0.84	0.00	
0580	Erie	24	22	63	2	111
		21.62	19.82	56.76	1.80	
0590	Fargo	54	26	69	0	149
		36.24	17.45	46.31	0.00	
0600	Fayetteville	26	23	64	1	114
		22.81	20.18	56.14	0.88	
0610	Fayetteville	65	68	104	3	240
		27.08	28.33	43.33	1.25	
0620	Fort Harris	34	15	61	2	112
		30.36	13.39	54.46	1.79	
0630	Fort Howard	34	41	103	1	179
		18.99	22.91	57.54	0.56	
0640	Fort Lyon	164	63	89	4	320
		51.25	19.69	27.81	1.25	
0650	Fort Meade	94	73	166	2	335
		28.06	21.79	49.55	0.60	
0660	Fort Wayne	31	29	81	1	142
		21.83	20.42	57.04	0.70	
0670	Fresno	33	25	90	1	149
		22.15	16.78	60.40	0.67	
0680	Gainesville	140	56	135	0	331
		42.30	16.92	40.79	0.00	
0690	Grand Island	22	23	47	0	92
		23.91	25.00	51.09	0.00	
0700	Grand Junction	9	7	41	1	58
		15.52	12.07	70.69	1.72	
0710	Hampton	90	68	160	1	319
		28.21	21.32	50.16	0.31	
0720	Hines	67	44	738	0	849
		7.89	5.18	86.93	0.00	
0740	Hot Springs	25	26	58	0	109
		22.94	23.85	53.21	0.00	
0750	Houston	184	95	546	2	827
		22.25	11.49	66.02	0.24	
0760	Huntington	30	55	53	2	140
		21.43	39.29	37.86	1.43	
0770	Indianapolis	65	27	197	3	282
		23.05	9.57	66.31	1.06	
0771	Indianapolis	13	2	64	0	79
		16.46	2.53	81.01	0.00	
0780	Iowa City	45	40	133	2	220

TABLE OF STNAME BY CNP84REC—Continued

[CNP84REC C&P status; in frequency and percent]

Row	Medical center	Service connected	Pension	Non-service connected	Prisoners of war	Total
		20.45	18.18	60.45	0.91	
0790	Iron Mountain	26	35	72	0	133
		19.55	26.32	54.14	0.00	
0800	Jackson	103	90	130	0	323
		31.89	27.86	40.25	0.00	
0820	Kansas City	90	43	206	1	340
		26.47	12.65	60.59	0.29	
0830	Kerrville	47	31	81	3	162
		29.01	19.14	50.00	1.85	
0840	Knoxville	82	71	157	0	310
		26.45	22.90	50.65	0.00	
0850	Lake City	57	96	96	1	250
		22.80	38.40	38.40	0.40	
0860	Leavenworth	64	97	175	1	337
		18.99	28.78	51.93	0.30	
0870	Lebanon	213	217	263	5	698
		30.52	31.09	37.68	0.72	
0880	Lexington	162	119	205	1	487
		33.26	24.44	42.09	0.21	
0881	Lexington C	61	44	112	0	217
		28.11	20.28	51.61	0.00	
0890	Lincoln	27	22	74	1	124
		21.77	17.74	59.68	0.81	
0900	Little Rock	81	66	162	1	310
		26.13	21.29	52.26	0.32	
0901	Little Rock	186	175	290	4	655
		28.40	26.72	44.27	0.61	
0910	Livermore	28	17	62	0	107
		26.17	15.89	57.94	0.00	
0911	Loma Linda	103	40	179	6	328
		31.40	12.20	54.57	1.83	
0920	Long Beach	240	111	465	5	821
		29.23	13.52	56.64	0.61	
0950	Los Angeles	88	191	187	1	467
		18.84	40.90	40.04	0.21	
0951	Los Angeles	122	31	279	1	433
		28.18	7.16	64.43	0.23	
0970	Louisville	86	80	100	3	269
		31.97	29.74	37.17	1.12	
0990	Lyons	384	163	400	1	948
		40.51	17.19	42.19	0.11	
1000	Madison	55	22	111	0	188
		29.26	11.70	59.04	0.00	
1010	Manchester	36	18	66	0	120
		30.00	15.00	55.00	0.00	
1030	Marion	31	36	67	3	137
		22.63	26.28	48.91	2.19	
1040	Marion	151	113	330	2	596
		25.34	18.96	55.37	0.34	
1050	Marlin	20	49	68	1	138
		14.49	35.51	49.28	0.72	
1060	Martinez	75	46	190	0	311
		24.12	14.79	61.09	0.00	
1070	Martinsburg	49	81	91	1	222
		22.07	36.49	40.99	0.45	
1080	Memphis	145	127	244	0	516
		28.10	24.61	47.29	0.00	
1090	Miami	152	113	253	1	519
		29.29	21.77	48.75	0.19	
1100	Miles City	10	12	20	0	42
		23.81	28.57	47.62	0.00	

TABLE OF STNAME BY CNP84REC—Continued

[CNP84REC C&P status; in frequency and percent]

Row	Medical center	Service connected	Pension	Non-service connected	Prisoners of war	Total
1110	Minneapolis	180	82	321	2	585
		30.77	14.02	54.87	0.34	
1120	Montgomery	33	52	47	0	132
		25.00	39.39	35.61	0.00	
1130	Montrose	425	132	372	1	930
		45.70	14.19	40.00	0.11	
1140	Mountain Home	78	118	143	2	341
		22.87	34.60	41.94	0.59	
1150	Murfreesboro	172	63	259	0	494
		34.82	12.75	52.43	0.00	
1160	Muskogee	37	44	41	1	123
		30.08	35.77	33.33	0.81	
1170	Nashville	96	69	158	2	325
		29.54	21.23	48.62	0.62	
1180	Newington	40	13	75	0	128
		31.25	10.16	58.59	0.00	
1190	New Orleans	78	61	215	2	356
		21.91	17.13	60.39	0.56	
1200	New York	145	156	363	0	664
		21.84	23.49	54.67	0.00	
1210	North Chicago	212	131	425	5	773
		27.43	16.95	54.98	0.65	
1220	Northampton	195	56	167	9	427
		45.67	13.11	39.11	2.11	
1230	Northport	301	0	374	0	675
		44.59	0.00	55.41	0.00	
1240	Oklahoma City	91	54	149	0	294
		30.95	18.37	50.68	0.00	
1250	Omaha	59	56	182	1	298
		19.80	18.79	61.07	0.34	
1260	Palo Alto	197	24	218	1	440
		44.77	5.45	49.55	0.23	
1261	Palo Alto M	210	10	166	1	387
		54.26	2.58	42.89	0.26	
1270	Perry Point	279	156	262	1	698
		39.97	22.35	37.54	0.14	
1280	Philadalphia	81	57	130	6	274
		29.56	20.80	47.45	2.19	
1300	Phoenix	82	23	225	5	335
		24.48	6.87	67.16	1.49	
1310	Pittsburgh	216	86	242	0	544
		39.71	15.81	44.49	0.00	
1320	Pittsburgh	93	96	149	3	341
		27.27	28.15	43.70	0.88	
1321	Pittsburgh	19	32	43	1	106
		17.92	30.19	50.94	0.94	
1330	Poplar Bluff	27	31	56	1	115
		23.48	26.96	48.70	0.87	
1340	Portland	84	53	130	0	267
		31.46	19.85	48.69	0.00	
1341	Portland VA	35	11	75	0	121
		28.93	9.09	61.98	0.00	
1350	Prescott	31	26	84	1	142
		21.83	18.31	59.15	0.70	
1360	Providence	77	34	86	1	198
		38.89	17.17	43.43	0.51	
1370	Reno	28	57	28	2	115
		24.35	49.57	24.35	1.74	
1380	Richmond	117	112	248	2	479
		24.43	23.38	51.77	0.42	
1390	Roseburg	43	40	117	2	202

TABLE OF STNAME BY CNP84REC—Continued

[CNP84REC C&P status; in frequency and percent]

Row	Medical center	Service connected	Pension	Non-service connected	Prisoners of war	Total
		21.29	19.80	57.92	0.99	
1400	Saginaw	31	25	44	0	100
		31.00	25.00	44.00	0.00	
1410	Salem	222	138	233	2	595
		37.31	23.19	39.16	0.34	
1420	Salisbury	236	213	279	1	729
		32.37	29.22	38.27	0.14	
1430	Salt Lake City	75	24	211	3	313
		23.96	7.67	67.41	0.96	
1440	San Antonio	180	86	283	4	553
		32.55	15.55	51.18	0.72	
1460	San Diego	102	9	192	2	305
		33.44	2.95	62.95	0.66	
1480	San Francisco	65	21	119	3	208
		31.25	10.10	57.21	1.44	
1490	San Juan	337	41	228	2	608
		55.43	6.74	37.50	0.33	
1500	Seattle	85	27	109	2	223
		38.12	12.11	48.88	0.90	
1510	Sepulveda	118	38	236	0	392
		30.10	9.69	60.20	0.00	
1520	Sheridan	66	45	152	1	264
		25.00	17.05	57.58	0.38	
1530	Shreveport	77	68	93	0	238
		32.35	28.57	39.08	0.00	
1540	Sioux Falls	39	33	94	1	167
		23.35	19.76	56.29	0.60	
1550	Spokane	47	48	59	1	155
		30.32	30.97	38.06	0.65	
1560	St. Cloud	146	132	219	3	500
		29.20	26.40	43.80	0.60	
1570	St. Louis	44	56	177	5	282
		15.60	19.86	62.77	1.77	
1571	St. Louis JE	87	66	221	0	374
		23.26	17.65	59.09	0.00	
1590	Syracuse	65	45	130	0	240
		27.08	18.75	54.17	0.00	
1600	Tampa	179	59	264	2	504
		35.52	11.71	52.38	0.40	
1610	Temple	116	67	178	8	369
		31.44	18.16	48.24	2.17	
1620	Togus	94	46	178	0	318
		29.56	14.47	55.97	0.00	
1630	Tomah	125	116	224	5	470
		26.60	24.68	47.66	1.06	
1640	Topeka	231	91	329	5	656
		35.21	13.87	50.15	0.76	
1650	Tucson	52	34	132	4	222
		23.42	15.32	59.46	1.80	
1660	Tuscaloosa	155	48	264	1	468
		33.12	10.26	56.41	0.21	
1670	Tuskegee	190	173	291	1	655
		29.01	26.41	44.43	0.15	
1690	Waco	328	119	212	9	668
		49.10	17.81	31.74	1.35	
1700	Walla Walla	21	19	49	0	89
		23.60	21.35	55.06	0.00	
1710	Washington	129	66	325	3	523
		24.67	12.62	62.14	0.57	
1720	West Haven	112	39	234	0	385
		29.09	10.13	60.78	0.00	

TABLE OF STNAME BY CNP84REC—Continued

[CNP84REC C&P status; in frequency and percent]

Row	Medical center	Service connected	Pension	Non-service connected	Prisoners of war	Total
1750	White River	48	22	86	1	157
		30.57	14.01	54.78	0.64	
1760	Wichita	27	29	46	3	105
		25.71	27.62	43.81	2.86	
1770	Wilkes-Barre	124	58	138	2	322
		38.51	18.01	42.86	0.62	
1780	Wilmington	57	30	95	1	183
		31.15	16.39	51.91	0.55	
1790	Wood	102	69	221	0	392
		26.02	17.60	56.38	0.00	
	Total	17,720	10,833	29,516	289	58,358

Source: 1984 annual patient census, hospital care component—98 percent completion.

VA Sharing Program With Private Sector

Through the affiliated medical centers, many services and areas of expertise are provided through sharing agreements. Many of these agreements are negotiated at 20–30 percent discounts. In some instances, we avoid high-cost construction for special facilities.

This sharing program with the private sector is one of the most cost effective undertakings in the health care community at this time. Public Law 89–785, which contains U.S.C., Title 38, Section 5053, was enacted in 1966. This legislation came about in the era of health planning legislation. The focus of these laws was to contain health care costs and avoid duplication of expertise and expensive facilities such as Open Heart Surgery and Radiation Therapy. At the present time, Magnetic Resonance imaging is coming into the forefront for sharing. Generally, the program permits the VA to share its specialized medical resources with private sector hospitals, and vice versa.

The total program was $42.9 million for Fiscal Year 1984.

VA/DoD Sharing—During Fiscal Year 1984, 54 Veterans Administration Medical Centers shared services with 57 military facilities. Services covered in Fiscal Year 1984 are listed on the attachment (Attachment 1).

Fiscal Year 1984 was the first year of implementation for the VA/DoD Sharing Law. Most agreements were not negotiated until the second half of the fiscal year, therefore, cost savings or cost avoidance for the fiscal year is minimal. Fiscal Year 1985 figures will be more definitive.

ATTACHMENT 1

FY 1984 SHARED SERVICES BY PROGRAM AREA AT LOCAL VA/DOD FACILITIES
(38 U.S.C. § 5011)

MEDICAL SERVICES

Inpatient - 14

Outpatient

- Cardiology - 20
- Dermatology - 2
- Endocrinology - 2
- General Medicine - 9
- Gastroenterology - 4
- Allergy - 2
- Family Medicine - 1
- Pulmonary - 2
- Oncology - 65

SURGICAL SERVICES

Inpatient - 11

Outpatient

- General Surgery - 6
- Ophthalmology - 7
- Orthopedics - 7
- Vascular - 4
- Urology - 2
- Otolaryngology - 5
- OB GYN - 12
- Thoracic - 1
- Operating Room - 3

OTHER SERVICES

- Spinal Cord Injury - 2
- CT Scans - 14
- ICU - 5
- Nuclear Medicine - 17
- Podiatry - 5
- Research - 3
- Audiology/Speech - 13
- Optometry - 3
- Dietetics - 1
- Rehab Medicine - 10
- Pathology - 37
- Laundry - 10
- Dental (outpatient) - 10
- Blood Products - 6
- Space - 2
- Social Work - 3
- Engineering - 10
- Radiology - 3
- Neurology - 7 (inpatient)
- Neurology - 6 (outpatient)
- Education/ Training - 9
- Psychiatric - 7 (inpatient)
- Psychiatric - 6 (outpatient)
- Transportation - 5

CLINICAL ADDITION AND ALTERATIONS, PROJECT NO. 540-008, VAMC, CLARKSBURG, WV

EXPLANATION OF DELAY IN PRELIMINARY PLAN COMPLETION

(1) The project submission indicated a preliminary completion date of February 18, 1983. The actual date of completion was November 9, 1983. The slippage was due to the change in scope in the project. This change reflected Fiscal Year 1990 MEDIPP projections and added a 38-bed intermediate care nursing unit rather than 41 general medical bed unit, 5 new intensive care beds and a new surgical suite. This change was requested in January 1983 at the time preliminary design was almost complete. This scope change required a redesign effort which extended the completion date to November 1983. The Fiscal Year 1985 budget prospectus for this project did reflect this scope change. This project was funded in Fiscal Year 1985 for working drawings and construction. As such, the delay in preliminary plan completion had no effect on the working drawing award. Given the funding schedule, the earliest the working drawing award could be made was October 1984 (the beginning of Fiscal Year 1985).

EXPLANATION OF DELAY IN WORKING DRAWING AWARD

(2) The working drawing award was originally scheduled for October 16, 1984. The actual award date was February 22, 1985. The required audit for this award was requested on June 13, 1984. The audit was performed by DCAA Chicago Region, Pittsburgh Mobile Branch Office for TAG Architects and a desk audit performed by DCAA Alexandria Branch Office for VVKR. TAG Architects and VVKR are the joint venture designing this project. The audit was received on August 6, 1984. The resolution of issues raised by the audit and the negotiation of the final fee with the A/E took from August 6, 1984 until November 7, 1984.

(3) The A/E (TAG) previously had not been audited by the Federal Government. As noted above, the audit was received on August 6, 1984, with questioned costs and a differing opinion on overhead rates. The A/E also needed to resolve the division of work effort between the joint venture. Until these differences were resolved the fee could not be finally negotiated. (This took three months to resolve.) The total negotiated fee amount was then approved on November 7, 1984, in the amount of $1,216,450. Because the negotiated fee exceeded $1,000,000, approval of the Department of Labor was required.

(4) The contract forms and EEO forms were changed due to changes in the new Federal Acquisition Regulations and had to be resubmitted by the A/E joint venture firms. This delayed the award process one month. These forms were received from the joint venture on December 14, 1984. On December 21, 1984 we requested an EEO pre-award on-site compliance review. This review was accomplished by the Office of Federal Contract Compliance Programs/Employment Standard Administration/Region III in Philadelphia, Pennsylvania and received in the VA Project Director's office January 28, 1985.

(5) The contract was approved by the Director, Office of Construction (08) on February 6, 1985, subject to release of congressional notification letters. The congressional notification letters were signed on February 13, 1985 and received in Project Director's office February 19, 1985. The contract was awarded on February 22, 1985. (The reasons for the four month delay in awarding the working drawing contract are identified in paragraphs 2., 3. and 4.)

(6) A copy of the original and current schedule for this project is attached.

SCHEDULE INFORMATION

	As reflected in the project submission approved by the Administrator on November 16, 1982	As reflected in the fiscal year 1985 budget prospectus, January 1984	Current	Deviation in months
Preliminary plan award	Sept. 7, 1982	NA	Sept. 15, 1982A	0
Preliminary plan completion.	Feb. 18, 1983	Nov. 9, 1983	Nov. 9, 1983A	−9
Working drawing award	Oct. 16, 1984 [1]	NA	Feb. 22, 1985A	−4
Working drawing completion.	June 19, 1985	NA	Oct. 30, 1985	−4½
Invitations for bid	July 8, 1985	NA	Nov. 15, 1985	−4
Construction award	Oct. 1, 1985	NA	Feb. 13, 1986	−4½

SCHEDULE INFORMATION—Continued

	As reflected in the project submission approved by the Administrator on November 16, 1982	As reflected in the fiscal year 1985 budget prospectus, January 1984	Current	Deviation in months
Construction completion	Apr. 17, 1989 [2]	Feb. 12, 1988	Apr. 18, 1988	+12

[1] Fiscal year 1985.
[2] Refinement of project construction phasing requested in shortened completion time.

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
Washington, DC, January 29, 1985.

Hon. HARRY N. WALTERS,
Administrator, Veterans Administration,
Washington, DC.

DEAR MR. WALTERS: As you may know the 1984 Veterans Administration Medical District Initiated Program Planning (MEDIPP) study includes a recommendation to establish an ambulatory care facility in New Jersey through the FY 1987 budget. Of the entire VA Medical District IV—which encompasses New Jersey, Delaware and parts of Maryland and Pennsylvania—the New Jersey site is recognized as the highest priority. The facility, better known as a "satellite outpatient clinic", will treat minor surgery, fill pharmaceutical needs and provide local diagnostic and rehabilitative services.

The Veterans Administration has relied upon these locally placed facilities as a means of lessening the workload at the primary VA Medical Centers. This far-sighted policy is based on the idea that adapting to the geographical changes in veteran population is less expensive in the long term. Additionally the medical care for comparatively minor problems can be offered at a local and more convenient level for the veteran.

The nearly one million veterans of New Jersey have suffered despite this theory for many years. The only outpatient facility in the state is located in Newark and has been victimized by staffing shortages and equipment breakdowns. VA statistics indicate that there are parts of New Jersey which are capable of providing over 52,000 visits per year by veterans to such a facility. The minimum threshold cited by the VA for the placement of a clinic in only 15,000 visits annually, less than one-third of the projected annual total for the New Jersey site.

While we are aware of the necessity for fiscal restraint this year, we are convinced that the case for a VA satellite outpatient clinic in New Jersey is so compelling that inclusion of such a clinic in the 1986 budget is warranted. From a demographic perspective, the elderly population in New Jersey is growing at a tremendous rate. This added crunch will place further stress on a veterans health care network that is already chronically overtaxed.

As federal policymakers, we are acutely concerned about meeting the needs of the millions of World War II and Korean War veterans who will become eligible for free health care benefits over the next 15 years. The recent VA study, "Caring for the Older Veteran," predicted that by 1990, 7.2 million veterans will be over age 64, doubling 1980's total. We have the opportunity before us this year to establish a facility to serve the unmet demand which existed before 1980, while simultaneously preparing for the continuing influx of older veterans to our region. It is for these men and women that we repeat the recommendations of that report and the recommendations of health professionals in the field. The establishment of an outpatient clinic in New Jersey is a priority and it must be a priority this year.

We are ready and willing to work with you through the legislative process this year to facilitate this action. As the elected representatives of the nearly one million New Jersey veterans it is our honor and privilege to work towards such a goal.

Sincerely,

Christopher H. Smith, Frank R. Lautenberg, Matthew J. Rinaldo, Jim Saxton, Marge Roukema, James J. Florio, Bill Bradley, Jim Courter, Dean A. Gallo, James J. Howard, Frank J. Guarini, William J. Hughes, Robert G. Torricelli, Robert A. Roe, Bernard J. Dwyer, Peter W. Rodion, Jr.

STATEMENT OF DAVID W. GORMAN, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR FOR MEDICAL AFFAIRS, DISABLED AMERICAN VETERANS

Mr. Chairman and members of the Subcommittee: On behalf of the 950,000 members of the Disabled American Veterans, I would like to take this opportunity to thank you and the members of the Subcommittee for allowing us this opportunity to present our views on the VA's Medical Construction Program for Fiscal Year 1986.

As you know, Mr. Chairman, the VA's request for construction programs in Fiscal Year 1986 calls for budget authority of $611.6 million, of which approximately $552.9 million is devoted to the health care system. While the total program level requested is $771.6 million, this figure is artificially inflated due to the proposal to reprogram $160 million in prior budget authority from the major working reserve.

Highlights of the Medical Construction Program include:

$261 million in replacement and modernization projects;

$188.5 million in general and miscellaneous projects to accomplish certain renovations, modifications, remodeling and other general improvements in support services;

$52.4 million in clinical improvements;

$42.2 million in fire and safety improvements;

$23.7 million to increase domiciliary capabilities;

$23.3 million to increase nursing home care capabilities; and

$2 million for outpatient improvements.

Mr. Chairman, the DAV believes it important to place the Construction Program in its proper context to the Department of Medicine and Surgery. In our opinion, the delivery of quality health care to this nation's veterans entails a commitment to modern, safe and efficient medical care facilities.

To fulfill this commitment it is necessary that the VA provide, on a continuing basis, for the resasonable expansion, renovation, modernization and replacement of its medical facilities.

When reviewing the VA's Fiscal Year 1986 construction request for medical programs, it becomes evident that the agency's ability to provide that quality care is, in our view, being placed in jeopardy.

Simply stated, Mr. Chairman, while we support full funding of the proposed Construction Program we are nevertheless concerned, not only with the quality of care provided but also concerned about the VA's ability to meet the pressing demands being placed upon the health care system.

The DAV is concerned, as I know you are Mr. Chairman, with how the VA will provide quality health care to the rapidly increasing aging veteran population.

According to VA statistics, there were 3 million veterans age 65 and older in 1980, constituting 10.5% of the total veteran population. By 1990 this figure is expected to rise to 7.2 million, representing 26.6% of the total and by the year 2000, the number will reach 9 million, translating to 37% of the veteran population.

We know that greater number of elderly veterans are seeking nursing home care from the VA, yet, of this Medical Construction Budget, only 4.2% ($23.3 million) is requested for nursing home care bed construction, conversion, renovation and relocation.

We are aware of and support the VA's proposal to convert 204 hospital beds to nursing home care beds, as well as efforts to replace and modernize other nursing home care facilities. However, as the demand rapidly increases for nursing home care beds, we would urge the VA to proceed on a swift timetable concerning conversion of beds, while maintaining an appropriate balance to meet the acute and intermediate health care needs of our aging veteran population.

Mr. Chairman, the DAV has an inherent interest in the maintenance of VA hospital beds for the care and treatment of all eligible veterans. Yet, the Fiscal Year 1986 Budget projects the loss of 1,000 more hospital beds next year. This proposed reduction will bring the total loss of hospital beds within the confines of the system to 4,500 since 1981. Conversely, the VA has added only 2,800 nursing home care beds to the system over the same period.

An obvious violation of Section 5010(a)(1), Title 38, United State Code, exists by operating and maintaining 89,100 hospital and nursing home beds. Additionally, when viewing the five year pattern mentioned earlier, it becomes obvious that a greater number of hospital beds are being closed than nursing home care beds are being added to the system—a net loss of 1,700 beds since 1981.

Mr. Chairman, in our view, the continued shutdown of beds is simply a waste of available resources. Considering the current demand for nursing home care and the rate at which nursing care beds are added to the system, we would encourage the

VA to direct greater attention to the conversion of beds already closed (or to be closed) to nursing care beds.

The VA's five year Medical Facility Construction Needs Assessment addresses three major areas of emphasis within the agency's long range Construction Program:

(1) To build and/or modernize existing facilities to accommodate program growth or realignment based upon patient need and demand, as documented by demographic and utilization data.

(2) To meet the functional and space requirements of modern medicine.

(3) To correct cited deficiencies in the areas of patient environment and safety, and to maintain the standards of accreditation.

As you know Mr. Chairman, the Medical District Initiated Program Planning (MEDIPP) is used as a plan to assess the system's future needs based upon a medical district perspective and the shift in the veteran population.

Additionally, MEDIPP is capable of assisting in the Construction Program by integrating grassroots, programmatic planning; developing early conceptualization of facility construction needs; and by expanding the flexibility of space criteria to meet changes in mission requirements.

Mr. Chairman, the DAV supports the facility planning process embodied in MEDIPP—making the most cost effective use of resources in funding that is available. The program should continue to provide input in the construction planning process.

ADVANCE PLANNING FUND/DESIGN FUND

The VA's Fiscal Year 1986 construction request includes $19 million for the Advance Planning Fund (APF). As we understand it, the APF is designed to provide flexibility to explore various corrective strategies, propose alternative conceptual approaches and enable informed decisions to be made.

The APF is used to develop an appropriate concept to correct existing deficiencies in VA Medical Centers and/or to upgrade facilities for the future provision of medical care to veterans.

The VA is requesting $20 million in Fiscal Year 1986 for the Design Fund. This fund, with certain restrictions, permits the VA to initiate working drawings for construction projects prior to Congressional approval for funding.

Mr. Chairman, following completion of preliminary planning through the APF process, the Design Fund permits the VA to proceed directly from the advance planning stage into the working drawing stage.

Additionally, by using this process, an average delay of 15 months is eliminated, thereby producing savings to the VA by the avoidance of additional inflationary costs.

Mr. Chairman, if in fact the flexibility provided by the APF is beneficial and taxpayer dollars are saved by eliminating unwarranted delays as suggested by the mechanics of the Design Fund, the DAV supports full funding of these items in the Construction Budget.

GRANTS FOR CONSTRUCTION OF STATE EXTENDED CARE FACILITIES

The VA's Fiscal Year 1986 request for grants for construction of state extended home care facilities is $22 million, a dramatic decrease of $12.5 million from the Fiscal Year 1985 level of $34.5 million.

As you are aware Mr. Chairman, this program provides grants to assist states to acquire or construct state home facilities for furnishing domiciliary or nursing home care to veterans and to expand, remodel, or alter existing buildings for furnishing domiciliary, nursing home, or hospital care to veterans in State Homes.

Under the current program a grant may not exceed 65% of the total costs of the project and grants to any one state may not exceed ⅓ of the amount appropriated in any one fiscal year.

The VA's Fiscal Year 1986 request of $22 million will provide for an additional 450 nursing home beds as well as 126 convertible domiciliary/nursing home beds.

Without question, Mr. Chairman, the domiciliary, nursing home and hospital care provided to this nation's veterans by State Veterans Homes has been invaluable in terms of offsetting the severe losses suffered by the VA's health care system which I discussed earlier.

During Fiscal Year 1985 the State Veterans Homes will maintain an average daily census of 8,200 nursing home, 4,469 domiciliary and 516 hospital patients. In Fiscal Year 1986, State Nursing Homes and domiciliaries average daily census is projected to increase by 618 and 248 respectively.

Recognizing the significance and important role of the State Veterans Homes—in terms of care provided to the rapidly aging veteran population and the cost effective use of federal taxpayer dollars that supplement this program—we believe it is indeed shortsighted and unwise to cut funds in a program that ultimately produces savings to the government in terms of both construction and health care costs.

Mr. Chairman, earlier in my testimony I discussed aging veterans and the demands they will place on the system. In our view, the VA is faced with a second "aging challenge," that of its medical care facilities.

The DAV has always been supportive of the VA's Medical Construction Program. However, the fact is that the capital plant of the VA health care system is deteriorating and will continue to do so at a rapid pace. One reason for this deterioration is, in our view, that the VA is attempting to play "catch up" with respect to renovations due to what could be classed as severe underfunding over a long period of time.

The average age, from the original construction date of all VA Medical Centers is 45.2 years; 68 VA Medical Centers are 50 years old or older; and nine VA Medical Centers saw their original construction during the 1800's.

Mr. Chairman, this budget request does not go far enough to allow the VA to accomplish what it must accomplish if the system—which represents the American taxpayers multi-billion dollar investment—is to remain viable.

As veterans grow older their need for medical care becomes greater, at more frequent intervals and the complexities of treatment grow more costly. Likewise, the condition of VA health care facilities cannot escape unscathed from the effects of age.

Mr. Chairman, the VA is now proceeding with a Capital Facilities Study at 130 of its VA Medical Centers which will assess each existing building (and system within each building) to determine the overall physical condition of the facility.

This study should yield results identifying deficiencies that require immediate correction, as well as establish long-term plans pertaining to the Medical Construction Program.

Mr. Chairman, the DAV supports this major undertaking and we urge the VA to proceed as quickly as possible to complete this vital study.

Mr. Chairman, this completes my statement. Again, the DAV appreciates having been given the opportunity to present our views on this most important subject.

WRITTEN COMMITTEE QUESTIONS AND THEIR RESPONSE

CHAIRMAN EDGAR TO VETERANS' ADMINISTRATION

Question 1. Would it be logical to include in the five year plan alternatives to construction of VA medical facilities where it is necessary to spend a total of more than $2 million for the facility?

Answer. As part of the individual medical centers facility planning and the Medical District Initiated Program Planning (MEDIPP) processes, programmatic needs are identified and alternative solutions are explored. Non-construction alternatives, such as leasing or the sharing of resources with an outside entity, are explored during the A-104 process. Where non-construction alternatives were explored, they will be included in the narrative description of proposed construction included in the Needs Assessment.

Question 2. The Committee recently received a list of outpatient clinics currently operating in leased space. What is the total annual leasing cost of these facilities? What is the average term of these leases? Is it true in some cases the VA is committed to leases which won't expire until the year 2001?

Answer. The total annual leasing cost to the VA for the outpatient clinic facilities listed is $22,060,035.98. Of this total, $11,562,987.31 is for Standard Level User Charge (SLUC) payment to GSA for outpatient clinics in Federal buildings (rental payments paid to GSA by the VA), and $10,497,048.67 is for VA rental payments to private sector lessors. The average lease term of the private sector leases listed is 9.69 years. The term of occupancy for outpatient clinic facilities located in Federal buildings owned and controlled by GSA is considered to be indefinite. However, if the VA has a need to relinquish space in any building under GSA control, the Federal Property Management Regulations provide for cancellation of Federal agency SLUC payments to GSA upon 120 days written notice that an agency desires to vacate the space. It is true that the VA has two leases which will not expire until the year 2001.

Question 3a. Using as examples several recent leasing agreements entered into by the VA, the trend seems to be to enter into long-term leases of 10, 15, or even 20 years. Is this correct?

Answer. Leases for VA satellite outpatient clinics are usually written for 10-to-20 year terms. The reasons for this action are three-fold: First, most lessors require lease terms which are sufficient in length to amortize the cost of construction loans. In the absence of long-term tenant commitments, it is difficult, if not impossible, to induce lenders to underwrite loans at favorable interest rates. Second, it is in the Agency's interest to secure a long-term interest in the property under lease considering the cost of special purpose alterations required for clinic space. Third, we find that long-term leases result in more favorable rental costs.

Question 3b. Depending on size and location, a decision to lease a space for an outpatient clinic could commit the VA to spend over $10 million during the life of the lease. Can you explain why the VA almost invariably decides to lease space for satellite outpatient clinics rather than building the clinic?

Answer. The results of a Life Cycle Cost Analysis (LCCA) which compares the cost effectiveness of leasing versus building or purchasing required space is considered prior to making a determination on the best method of acquisition. Most often, the results of the LCCA have a direct bearing on the final determination of the most economical acquisition alternative. However, in some instances, other factors outweigh the difference in cost between alternatives and are used as the basis for our determination. Admittedly, our LCCA results have most often concluded that leasing is more cost effective.

Question 4. Well over half of the leases administered by the VA are subject to escalation (19 out of 31). Isn't it also correct that costs for space leased from GSA are increased annually by the GSA? How can you compare the cost of building versus the cost of leasing when one cost is fixed and the other is open-ended?

Answer. The cost of most outpatient clinic space leased from GSA by the VA is expected to increase each year, by means of increased Standard Level User Charge (SLUC) billings. However, for FY 1983 and FY 1986 the SLUC rate has been frozen by the Congress to the rate of the previous year. The GSA billing is for full service rental (net rent plus services and utilities). Most VA-administered leases only have escalation for services and utilities, not the base rent. The costs of services and utilities are considered to be equal whether the VA leases or builds, and therefore these costs are excluded from the A-104 study. Both lease and build options are compared on a fixed rate basis.

Question 5. An economic analysis dated February 6, 1985, was enclosed with your February 15, 1985 letter to Chairman Montgomery. The analysis assumes a base condition of 7% discount. What does this mean? Can you explain why a 7% discount is chosen rather than a 5% or 10% discount? Please tell us whether the lease contemplated is a fixed lease or subject to escalation? Doesn't this analysis assume a fixed leasing cost of $11.95 a square foot? Please explain your decision to proceed with a lease under these conflicting circumstances.

Answer. The base condition of a 7% discount used for the economic analysis (Life Cycle Cost Analysis) enclosed with the February 15 letter to Chairman Montgomery is prescribed by Office of Management and Budget (OMB) Circular A-104, dated June 14, 1972. The Circular describes in detail the meaning and rationale for using this particular percentage. The VA does not have the option of choosing a 7% discount factor, but is required, along with all other Federal agencies, to follow OMB direction when conducting an economic analysis of this type. The lease for Pensacola VA outpatient clinic has a fixed rate of $11.95 per square foot. The escalation provision in the lease is only for actual increased costs of outside maintenance (building and grounds) over an established base rate. This is not conflicting, but is consistent with the Life Cycle Cost Analysis procedure which assumes that the costs of outside maintenance would be equal, whether the outpatient clinic occupies leased or VA-constructed space.

Question 6. If the result of these A-104 cost analyses is a decision that leasing is almost more cost-effective, should the VA be looking at leasing other medical facilities such as nursing homes?

Answer. The VA prepared a draft study comparing the total costs to the Government of a VA nursing home constructed, owned and operated by the VA versus a nursing home constructed and owned by a private interest and leased to and operated by the VA. The preliminary findings of the study concluded that it was more cost-effective for the VA to construct than lease from the private sector a nursing home over a 20-year period.

This draft study was subsequently provided to the American Health Care Association (AHCA), an association which represents member nursing homes. Several meet-

ings have been held with representatives of that association, including officials of the Americare Corporation of Columbus, Ohio. Copies of the study also were provided to Beverly Enterprises and several meetings and discussions have been held with that group. In addition, AHCA has made copies of the study available to some of their member groups, including the California Association of Health Facilities. The VA also transmitted a copy of the study to TransCon Builders of Washington, D.C., who in turn were going to provide VA with a copy of their financial analysis of a private sector nursing home care facility.

Comments were received from the various groups and pertinent exchanges made. In particular, Americare provided an analysis of the VA's draft Build/Lease Study to the Senate Veterans Affairs Committee (SVAC). The VA's response to the Americare analysis was provided to the SVAC during the FY 1985 budget deliberations.

Most recently, AHCA by letter of June 25, 1984, requested specific information from the VA to assist AHCA in their analysis of the Build/Lease Study. To date, we have not received AHCA's response to the data provided by the VA.

The VA still considers its draft Build/Lease Study a preliminary document and will continue to pursue further review and refinement with private sector groups. At this juncture, however, we find that our preliminary study finding that it is more cost-effective to build a nursing home rather than lease over a 20-year period is still valid.

Question 7. In November 1984, the VA sent the committee a list of planned mission changes as the result of MEDIPP. Ten of these changes involved outpatient clinics, with a recommendation that seven new clinics be added. When are they planned to be activated?

Answer. The recommendations mentioned arose out of the 1983 MEDIPP planning cycle. During the 1984 planning period, it was necessary to revalidate all proposed satellite outpatient workloads in order to establish an approximate priority order for the currently proposed outpatient clinic projects. This ranking will be used by the Agency to determine which projects are to be included in future budget proposals to the Congress.

Question 8. Were clinics at Crown Point, Indiana and Ponce, Puerto Rico identified as clinic sites in previous MEDIPP cycles? Why weren't the clinics in Southwest Oklahoma, East Texas, and Duluth, Minnesota mentioned in the Administrator's most recent letter discussing outpatient planning?

Answer. Outpatient clinics proposed for Crown Point, Indiana and Ponce, Puerto Rico were approved as a result of the 1982 MEDIPP process and were identified in the Administrator's statement released in May, 1983, outlining the expansion of VA health services. Clinics cited for establishment in Southwest Oklahoma, East Texas and Duluth, Minnesota were approved in the 1983 MEDIPP cycle and were similarly announced by the Administrator in September, 1984, as mission changes. The three proposed clinics in Oklahoma, Texas, and Minnesota were not mentioned in the Administrator's letter of February 15, 1985 to Congressman Montgomery because that letter only indicated outpatient clinic sites for which leasing arrangements had been approved by the Administrator. While these three proposed clinics have been approved for planning in the MEDIPP process, they are in the early stages of development, and no determination has been made as to the method of space acquisition. In addition, completion of the three proposed projects would depend on system-wide priorities and availability of budget resources.

Question 9. Please explain what was meant in the Administrator's February 15th letter to Mr. Montgomery when it was stated, "Congress directed the VA in the FY 1981 appropriation to establish an outpatient clinic in Northwest Florida." Please clarify what was meant by this statement?

Answer. In the Senate reports accompanying the Department of Housing and Urban Development—Independent Agencies Appropriation Bills, 1979 and 1980, the committee urged that the Agency lease space for an outpatient clinic in the northwest portion of the State of Florida. In FY 1981, the committee strongly recommended that the Agency lease space for this purpose. That same year, the Committee of Conference agreed that an outpatient clinic be established in the State of Florida. Taken as a whole, the issue of establishing a clinic there was interpreted as being directional in nature.

Hon. John Paul Hammerschmidt to Veterans' Administration

Question 1. Can you provide for the record why costs vary as between construction of VA nursing beds and private sector beds that are used by VA under contract?

Answer. The VA budget estimates are based on previous VA experience. They also reflect the cost impact of social policy programs mandated by law for Federal construction projects, which raise the cost of public construction above that for the private sector. It is not always clear that cost figures cited for private sector facilities are similarly all inclusive.

Construction standards established by law for VA nursing homes frequently are somewhat more stringent than those with which non-governmental facilities must comply. Private sector nursing homes may be of combustible construction. VA nursing homes are required to be of noncombustible construction. Moreover, as a matter of policy for patient protection, each new VA nursing home is equipped with a complete system of automatic sprinklers.

Cosnistent with its unique mission regarding treatment and rehabilitation of physically handicapped veterans, the VA requires all of its new facilities to be barrier-free throughout. Private sector facilities generally do not conform to the same stringent standards.

Various other factors, considered on a facility specific basis, often increase the cost of our facilities. Some of these factors are:

First floor of building elevated due to flooding hazard;
Parking may be beneath building;
Special foundations required by soil conditions;
Special provisions for earthquake resistant construction;
Structural capacity for future additional floors.

Nonetheless, the VA has developed a prototype design for nursing home. the prototype was developed using an integrated architectural Computer Aided Design (CAD) System. Initially the VA established a task force on Nursing Home Care Cost Reduction. The prototype design incorporates the task force cost reduction items within the CAD system. Recently, the GAO reviewed the costs of construction VA nursing homes compared to nursing homes constructed by the states. The study indicated that the VA cost was comparable to that of the states.

Question 2. If VA let the private sector build nursing beds and then leased them, is there any impact of the Davis-Bacon Act or other laws which apply if VA builds?

Answer. If the private sector builds nursing [home] beds which are leased by the VA, neither the Davis-Bacon Act, the Buy *American Act* nor the Contract Work Hours and Safety Standards Act would apply. OSHA would apply, but because OSHA standards originally were derived from and are presently identical to those issued under the Contract Work Hours and Safety Standards Act, there would be no impact on safety.

Question 3. You are requesting two new domiciliaries as repalcements. Do you give higher priority in this area than you do to nurising beds or the State grant program? How do you make this judgment when the domiciliary program is somewhat static and the other programs are relatively volatile?

Answer. We do not give higher priority to domiciliaries over nursing home care beds or the State grant program. However, in order to present a balanced construction program for all categories of projects, we must consider replacement of facilities that are extremely antiquated and present serious life/safety deficiencies.

Question. 4. If Congress gave you more money for Houston for 1986, could you effectively use it?

Answer. No. Additional funds could not be effectively utilized in FY 1986.

Question 4b. If Congress gave you more money for Philadelphia for 1986, could you effectively use it?

Answer. Yes. The parking structure could be separated out and accelerated for an estimated construction award of $10.3 million in FY 1986.

Question 5. Will you please provide for the record your current plans on Puerto Rico. Pending new construction there, do you plan a new contract at Hato Ray and if so please give us the details.

Answer. The Veterans Administration is issuing a report on health care in Puerto Rico which includes a project to modernize the medical center at San Juan, established a VA-operated outpatient clinic in Ponce, and construct a 120-bed nursing home care unit and 10-bed blind rehabilitation unit at the VA medical center San Juan.

The modernization project will provide for a multitude of space and functional deficiencies at VAM & ROC San Juan to be corrected by constructing an addition to house psychiatric beds and increase the ambulatory care space along with the renovation of existing space.

The VA is in the process if establishing criteria for prioritizing construction projects from which construction projects will be selected for funding in any given

year. Therefore, we have not identified the specific years in which design and construction funds would be requested for the modernizatin project.

The VA has initiated action that will result in establishing a VA-operated outpatient clinic in Ponce, Puerto Rico, to replace the contract outpatient program there. In addition, the fiscal year 1985 construction budget included funds for the 120-bed nursing home care unit and 10-bed blind rehabilitation unit. This project is forecast for completion during the last half of fiscal year 1988.

The VA plans to renew its contract at the Hato Ray Psychiatric Hospital each year until such time as VA facilities are in place and operating to care for the veterans are in place and operating to care for the veterans currently being treated in contract care hospitals. Hospital rates are negotiated annually and the law does not permit the contract to extend beyond a twelve month period.

HON. JOHN PAUL HAMMERSCHMIDT, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ARKANSAS TO DAVID GORMAN, ASSOCIATE DEPUTY NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

Question 1. How much expansion of VA support of State Nursing Home projects would you advocate?

Answer. The VA's Fiscal Year 1986 Budget Request for grants for construction of state extended home care facilities is $22 million, a dramatic decrease of $12.5 million from the Fiscal Year 1985 level of $34.5 million. Information from the VA indicates that at the end of Fiscal Year 1984 there would be 38 unfunded projects totaling $84 million for which preapplications have been received. Utilizing the Fiscal Year 1985 appropriation of $34.5 million there should remain 28 projects totaling $49.5 million for which preapplications have been received and funds requested. Thus, only 41 percent of the funds required to approve grants for these projects could be obligated. We view this program as a viable and invaluable alternative to providing extended care to veterans and, therefore, urge the Fiscal Year 1985 funding level $34.5 million be, at a minimum, maintained.

Question 2. From the DAV visitation programs or visits around the country, how do you compare VA nursing bed units to beds leased under contract from the private sector? Please answer also as to State Veterans Homes. What is you assessment overall?

Answer. Initially, we believe that the VA should be and continue to be the primary provider of medical care services to eligible veterans. Realizing the increased demand for nursing home care by veterans and the VA's inability to meet the demand, the contract nursing home program can serve as an adequate alternative.

With the exception of an initial VA inspection, the need to meet state, federal and VA standards, as well as periodic visits to contract nursing homes by VA inspection teams to ensure quality of care, we are not in a position to comparatively judge the level of care provided by the VA versus the private sector. We would opinion, however, that the overall quality of care in VA facilities exceeds nursing home care provided in other settings.

We feel the level of care needs required by veterans maintained in VA facilities is higher than in non-VA facilities and VA's experience in caring for the total needs of veterans exceeds that found in the private sector. The myriad of activities and recreational events provided in VA nursing homes via Veterans Administration Volunteer Service helps to meet an otherwise unfulfilled social void that is not paralleled in the private sector.

Overall, we are of the belief that care provided to veterans in VA nursing homes exceeds that provided in the private sector.

Statement of the
American Health Care Association

VETERANS ADMINISTRATION MEDICAL CONSTRUCTION PROJECTS

Statement by

Jeneen Erickson
Yorkshire Manor Nursing Home
Minneapolis, Minnesota

Before the
House Veterans Affairs Committee

March 5, 1985

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For Futher Information Contact: Cheryl Beversdorf

I am Jeneen Erickson, a registered nurse and owner/administrator of the Yorkshire Manor Nursing Home Facility in Minneapolis, Minnesota. I am pleased to be here to represent the American Health Care Association (AHCA). AHCA is the nation's largest association of long term care providers with a membership of over 8,500 facility-based providers in 48 states. This includes both proprietary and nonproprietary facilities providing a wide range of services in a variety of institutional settings. Our association is dedicated to quality long term health care for the nation's elderly, convalescent and chronically ill.

We appreciate the opportunity to present our views on Veterans Administration (VA) health facility construction. AHCA and its members have great respect for the VA and its health and medical programs for the nation's service veterans. Moreover, we strongly believe that the VA has played an important role in meeting the health care needs of these veterans and will continue to ably perform that function.

As the representative organization of the long term care industry, we empathize with the VA as they face the challenge of providing health care to a growing aging veteran population. It is inevitable that in order to respond to this dilemma, the VA must re-evaluate the health services they currently provide to their beneficiaries and to project what changes are needed in their program.

My purpose here today is to suggest ways in which the Veterans Administration and community nursing homes <u>together</u> can help meet the long term health care needs of our nation's veterans.

It is important to note that over the past several years, studies have been done by both the General Accounting Office (GAO) and the Congressional Budget Office (CBO) concerning the VA's commitment to the older veterans and how they will meet it. Both organizations acknowledge the VA's resource limitations and recommend, among other ideas, greater consideration of local conditions when the VA considers construction of its own nursing homes. We agree with this recommendation. In our experience, we have seen the VA's plans for building nursing homes in areas where there is an overabundance of community nursing home beds. It has also been suggested that the VA consider utilization of less costly alternatives. Specifically, in the GAO report, <u>VA Should Consider Less Costly Alternatives Before Constructing New Nursing Homes</u>, dated September 30, 1982, the GAO recommended that the VA "consider meeting nursing home needs whenever possible through greater use of the contract nursing home program." The CBO study, <u>Veterans Administration Health Care: Planning for Future Years</u>, April 1984, also recommended placing more veterans in community nursing homes, especially when it's determined that closer proximity to a VA hospital or the specialized skilled care offered only in a VA nursing home, is not a requirement for the patient.

In view of the growing elderly veteran population problem facing the VA, we hope the agency will increase its use of the contract community nursing home program. What's more, we believe there are other alternative health services for the elderly which could be rendered in the community which would assist the VA in meeting the demands of their mission while providing quality health care to their patients.

First, let me provide some information on the current contract community nursing home program. Through this program, the Veterans Administration Medical Centers contract for community nursing home care with private nursing homes. Medical centers negotiate all inclusive rates with nursing homes (room, meals, physician, nursing, pharmacy, lab and other services). Community nursing homes wishing to participate in the VA's program must meet state, federal and VA standards to assure that veteran patients placed in these facilities are receiving quality care. Frequently, the medical center will send an inspection team to make sure the community nursing home can meet the particular needs of a specific patient. The VA then refers appropriate patients (those whose needs the nursing home can meet) to the community nursing home. While the patient is a resident of that facility, the VA follows up with expert consultation and makes periodic visits as to the condition and progress of the patient. These visits usually include a social worker and often a nurse and special therapists who have worked with the veteran previously.

In our view, the community nursing home program is a success. Community nursing homes enjoy their involvement with the Veterans Administration contract program. First, facilities' staff benefit from the expert consultation and ongoing exchange with the medical center. Furthermore, the VA is known for paying their bills on time. Most importantly, AHCA has been told by the VA's Office of Extended Care that the VA has been satisfied with the quality care being provided in community nursing homes and its relationships with these homes.

Veterans placed in these facilities seem to be pleased with community nursing home placement. It is important to note that they are able to live closer to their friends and families then they might if residing in VA medical center hospitals and nursing homes. Community nursing homes provide a mixed male-female environment while most VA facilities are exclusively male.

In 1983, the community nursing home program supported an average daily census of 10,212 veterans, and supported the treatment of 34,092 total veteran patients. A small increase is expected in these numbers within the next few years.

With respect to program costs, in 1983 the Veterans Administration reported that the average per diem cost for providing service in its own nursing homes was $93.01 while costs for contracting with community nursing homes averaged $50.68 per day. We recognize a portion of this difference may be due to larger staff levels and higher salary rates in VA nursing homes. Nevertheless, we are convinced that community nursing homes do provide quality care while meeting VA standards and at a lower cost than in VA facilities.

The GAO is currently studying whether the care needs of VA nursing home patients are higher than the needs of veterans in community nursing homes. This should provide information as to whether higher costs in VA nursing homes are justified and whether veterans have unique health care needs. That study is due later this year.

The success of the contract community nursing home is an example of how the VA can address the problem of caring for the aging veterans. The contract program can and should be expanded. In analyzing the VA's FY86 budget, we were

disappointed to see that no request was made for expansion of this cost-effective, worthwhile program. Moreover, AHCA believes that the following alternatives should be explored:

1. Private construction of a nursing home which the VA could lease for its use. The facility would be privately built but operated by the VA to care for VA patients.

2. Private construction of a nursing home which the VA could lease for its use. However, in this case, the VA would contract out the management and staffing of the facility to care for VA patients. This would resemble the current contract program, but all patients, rather than just a few, would be placed in the facility by the VA.

3. Leasing by the VA of existing private nursing homes.

4. Contracting by the VA of a floor or wing of a private facility in addition to the current program of contracting single beds.

5. Negotiating different reimbursement systems with payment made according to skilled care requirements. For example, community nursing homes might develop special units to care for veterans with more acute needs such as the spinal cord injured or respirator dependent. Such an arrangement would require a special reimbursement rate to be determined between the medical center and the nursing home, which would cover the cost of the special care required for these patients. We know from our experience with the non-VA health care system that a community nursing home can provide such subacute care at one-half or less of the cost needed in a general hospital, and still maintain high standards of care.

The proposals mentioned above which pertain to leasing are particularly appealing to AHCA. Within our membership, there are several long term care companies which would be interested in constructing facilities and/or managing facilities for the VA's use. We believe this arrangement could be advantageous to the VA since demographic data indicates that the peak number of veterans in need of long term care will occur within the next twenty years. With long term leases, the VA could have the use of these facilities for twenty years. After its needs subside, the agency would not have empty beds with which to contend or "the empty school house syndrome," as it is called.

To determine whether leasing arrangements with the VA might be feasible, AHCA strongly urges the Congress to authorize the Veterans Administration to provide funds for demonstration projects in specifically designated geographic locations. These could be implemented in areas where the VA has demonstrated a need for additional beds in lieu of building a VA nursing home. We also suggest a demonstration program in which veterans with special needs are cared for in a community nursing home. An important component of such a program would include periodic evaluations by the VA to determine its cost effectiveness, and to assure quality care.

AHCA believes that in making these proposals, the involvement of the veterans, both the recipients themselves as well as the groups who represent them, should not be overlooked. In the past year, we have been in touch with representatives of all major veterans' groups and shared our thoughts and ideas with them. We welcome the opportunity to work with these organizations and their membership, especially on the state and local level. Some possible joint endeavors to involve them in community long term care might include volunteer and visitation programs and veteran employment initiatives.

Summary

The American Health Care Association believes that to help meet anticipated needs for caring for the elderly veteran, the Veterans Administration should increase its utilization of community nursing homes as well as consider other alternative arrangements for provision of needed services. The VA's mission to care for the nation's elderly veterans is not unlike that of AHCA's member facilities. We believe that working in concert with the VA to provide health care services more cost effectively while maintaining quality care for the patients, can be accomplished.

We would like the opportunity to develop programs which could explore new ideas to do this.

I would be happy to answer your questions.

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JAMES J. HOWARD
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CHAIRMAN
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March 5, 1985

The Honorable Bob Edgar
Chairman
Veterans Affairs Subcommittee on
Hospitals and Health Care
338 Cannon HOB
Washington, D.C. 20515

Dear Mr. Chairman:

As the Veterans Affairs Subcommittee on Hospitals and Health Care assesses the veteran health care needs of our nation, I wish to submit the enclosed testimony.

Consideration of the need to provide adequate health care for veterans in the Ocean County area of New Jersey by your Subcommittee would be greatly appreciated.

With best regards, I am

Sincerely,

James J. Howard

JAMES J. HOWARD
Member of Congress

JJH/tk

TESTIMONY
OF
THE HONORABLE JAMES J. HOWARD

Thank you Mr. Chairman. I appreciate the opportunity to submit testimony today as the Veterans Affairs Subcommittee on Hospitals and Health Care assesses construction needs for the veterans health care system. I wish to commend the Veterans Committee for its efforts to ensure that this country meets the health care needs of those who served when our country itself was in need.

The State of New Jersey is home to over 925,000 veterans or nearly one veteran in every seven residents. Approximately one out of every three and one half residents is a veteran dependent. The veterans health care network has been chronically overburdened for a number of years and, naturally, it is the veteran himself who suffers.

The Veterans Administration currently has under review the 1984 Veterans Administration Medical District Program Planning study (MEDIPPs). As you know, MEDIPPs uses a sophisticated computer projection to predict the medical needs of the VA's individual Medical Districts.

MEDIPPs has identified Ocean County, New Jersey in its draft form as the priority area for establishment of a medical facility in Medical District IV. As the Representative for New Jersey's Third Congressional District, which encompasses parts of Monmouth and Ocean Counties, I can attest to the fact that a veterans health facility is urgently needed in that area. As millions of World War II and Korean War Vetrans become eligible for health care benefits over the next 15 years, this need will only grow.

The Veterans Administration has in recent years turned to use of the "satellite outpatient clinic" as part of the effort to address the needs of those currently underserved. This reasoned policy is based on the idea that adapting to the geographical changes in the veterans population can lessen the load on primary VA Medical Centers.

In my area of New Jersey, veterans are forced to drive an hour or more to reach a VA facility. It is estimated that by 1990, veterans in the lower half of the state will require 52,000 visits a year. Yet no veterans facility exists south of Newark. Establishment of a satellite outpatient center in Ocean County is vital so that New Jersey's burgeoning veteran population can have the adequate and accessible health care it deserves.

I recognize the fiscal constraints imposed by the intolerable budget deficit the country is now running. We must make every effort to eliminate unnecessary or wasteful government expenditures so that the real needs of our country can be met while we maintain a sense of fiscal responsibility. However, when a real need such as an Ocean County VA facility presents itself, that need must be met. Therefore, I would urge the Committee's support in securing establishment of a satellite outpatient facility in Ocean County, New Jersey at the earliest possible time.